

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0995738

Reg. Dist. No.

9985

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood		c. LENGTH OF STAY IN 1b		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riderwood			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1603 Essex Farm Rd.				d. STREET ADDRESS 1603 Essex Farm Rd.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First JOHN	Middle F.	Last ACKERMAN	4. DATE OF DEATH Oct. 30 1956	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19, 1907	9. AGE (in years last birthday) 49 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Agent			10b. KIND OF BUSINESS OR INDUSTRY Insurance			11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Wm. F. Ackerman				14. MOTHER'S MAIDEN NAME Elizabeth Allen Crouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-05-7450		17. INFORMANT Mrs. Annie E. Ackerman 1603 Essex Farm Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO CORONARY Occlusion Coronary Insufficiency							
INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Elkridge	(County) Md.	(State) Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Charles F. O'Donnell				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 10/31/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/2/56	22c. NAME OF CEMETERY OR CREMATORIAL Meadowridge Mem. Pk.		22d. LOCATION (City, town, or county) Elkridge, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE John J. Schaefer & Sons - Balt. 17				ADDRESS 1603 Essex Farm Rd.	24a. RECD BY REGISTRAR Nov. 5, 1956	24b. REGISTRAR'S SIGNATURE Mabel Gray	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Give Pages 1, 2, and 3 to funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral director. File pages 1 and 2 with the registrar or removal.

VS. A15ME(5)
5M 9/55

DEPARTMENT OF HEALTH - LABORATORY
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
NOV 7 1956
FBI - BUREAU OF INVESTIGATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0995938
 Reg. Dist. No.

9986

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
BALTIMORE MARYLAND		N.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
55 Towson	1 wk.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
712 MURDOCK RD.		WILMINGTON 70x3	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last
	A	N	ANSWORTH
4. DATE OF DEATH	Month	Day	Year
	OCT.	20	1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Aug. 10, 1910
8. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
46 yrs.	Months Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
H.W.E.		—	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MD.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
HENRY F. DAHL MER		DEMME	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
NO		215-09-1475	
17. INFORMANT		Address Wilmington, N. C. Mr. Harry Ainsworth - 140 Lake Forest Pkwy.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 1/2 hrs	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		MYOCARDIAL INFARCTION	
(b) DUE TO HYPERTENSIVE CARDIOVASCULAR DISEASE		30 yrs	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
OBESITY			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE	DATE SIGNED		
EXAMINER'S NAME (Type)	William A. Pillsbury		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/23/56	22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cem.	22d. LOCATION (City, town, or county) Balto., Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE John J. Dickner & Sons - Balto. 17 Md.	ADDRESS	24a. REC'D BY REGISTRAR Oct. 22, 1956	24b. REGISTRAR'S SIGNATURE Mabel Gray

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

UNIVERSAL DIRECTOR: Page 3 should be used as a burial/cremation permit. File pages 1 and 2 with registrar prior to burial, cremation, or removal.

WISCONSIN STATE GOVERNMENT OF HIGHLIGHTS - EXHIBIT 18
WISCONSIN EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09958

38

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Carney</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>9802 Hilltop Drive</i>		d. STREET ADDRESS <i>9802 Hilltop Drive</i>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Mr.</i>	Middle <i>Thomas</i>	Last <i>Alder</i>	
4. DATE OF DEATH	Month <i>October</i>	Day <i>30th</i>	Year <i>1956</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 8, 1864</i>	
9. AGE (In years last birthday) <i>92</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	
13. FATHER'S NAME <i>John Alder</i>	14. MOTHER'S MAIDEN NAME <i>Mary Turnbull</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address <i>Mrs. Gertrude Jenkins, 9802 Hilltop Dr.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio-vascular-renal disease</i> DUE TO <i>442X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>20 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month <i>19</i>	Day <i>19</i>	Year <i>56</i>	
20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>2810 Taylor Ave</i>	(County) <i>Baltimore Co.</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Sept. 20 1956</i> , to <i>Oct. 30 1956</i> that I last saw the deceased alive on <i>Sept. 20 1956</i> , and that death occurred at <i>5:30 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>2810 Taylor Ave</i> DATE SIGNED <i>Leonard J. Ruck</i>				
ACTUAL SIGNATURE <i>G. M. Bacon</i>	PHYSICIAN'S NAME (Type) <i>A. M. BACON</i>	M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/2/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Carmel Cemetery</i>	22d. LOCATION (City, town, or county) <i>Baltimore Co. Maryland</i>	(State) <i>Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>	ADDRESS <i>5305 Harford Road #14</i>	24a. REC'D BY REGISTRAR <i>NOV 1 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. A. M. Bacon</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours of death.

CERTIFICATE OF DEATH

CHASMAN

DECEASED ON NOVEMBER TWENTY EIGHT, ONE THOUSAND NINETEEN FIFTY SIX

IN THE CITY OF SACRAMENTO, CALIFORNIA

BORN ON JUNE TWENTY EIGHT, ONE THOUSAND NINETEEN FORTY EIGHT

IN THE CITY OF SACRAMENTO, CALIFORNIA

DECEASED ON NOVEMBER TWENTY EIGHT, ONE THOUSAND NINETEEN FIFTY SIX

IN THE CITY OF SACRAMENTO, CALIFORNIA

BORN ON JUNE TWENTY EIGHT, ONE THOUSAND NINETEEN FORTY EIGHT

IN THE CITY OF SACRAMENTO, CALIFORNIA

DECEASED ON NOVEMBER TWENTY EIGHT, ONE THOUSAND NINETEEN FIFTY SIX

IN THE CITY OF SACRAMENTO, CALIFORNIA

BORN ON JUNE TWENTY EIGHT, ONE THOUSAND NINETEEN FORTY EIGHT

IN THE CITY OF SACRAMENTO, CALIFORNIA

DECEASED ON NOVEMBER TWENTY EIGHT, ONE THOUSAND NINETEEN FIFTY SIX

IN THE CITY OF SACRAMENTO, CALIFORNIA

BORN ON JUNE TWENTY EIGHT, ONE THOUSAND NINETEEN FORTY EIGHT

IN THE CITY OF SACRAMENTO, CALIFORNIA

DECEASED ON NOVEMBER TWENTY EIGHT, ONE THOUSAND NINETEEN FIFTY SIX

IN THE CITY OF SACRAMENTO, CALIFORNIA

BORN ON JUNE TWENTY EIGHT, ONE THOUSAND NINETEEN FORTY EIGHT

IN THE CITY OF SACRAMENTO, CALIFORNIA

DECEASED ON NOVEMBER TWENTY EIGHT, ONE THOUSAND NINETEEN FIFTY SIX

IN THE CITY OF SACRAMENTO, CALIFORNIA

BORN ON JUNE TWENTY EIGHT, ONE THOUSAND NINETEEN FORTY EIGHT

IN THE CITY OF SACRAMENTO, CALIFORNIA

DECEASED ON NOVEMBER TWENTY EIGHT, ONE THOUSAND NINETEEN FIFTY SIX

IN THE CITY OF SACRAMENTO, CALIFORNIA

BORN ON JUNE TWENTY EIGHT, ONE THOUSAND NINETEEN FORTY EIGHT

IN THE CITY OF SACRAMENTO, CALIFORNIA

DECEASED ON NOVEMBER TWENTY EIGHT, ONE THOUSAND NINETEEN FIFTY SIX

IN THE CITY OF SACRAMENTO, CALIFORNIA

BORN ON JUNE TWENTY EIGHT, ONE THOUSAND NINETEEN FORTY EIGHT

IN THE CITY OF SACRAMENTO, CALIFORNIA

BURKE V. S.

NOV 1 1956

REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

09960

Reg. Dist. No.

37

9988

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (rural)		c. LENGTH OF STAY IN 1b 12 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Belfast Rd.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparks (rural)	
3. NAME OF DECEASED (Type or print) <i>H. Almon</i> First: Howard Middle: Ellsworth Last: Almon		4. DATE OF DEATH Month: OCT. Day: 6 Year: 1956	
5. SEX male	6. COLOR OR RACE white	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 10-11-1882
		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 73 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) manager		10b. KIND OF BUSINESS OR INDUSTRY farm	11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Almon		14. MOTHER'S MAIDEN NAME Sarah E. Lloyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-22-0876	17. INFORMANT Mrs. Carrie Almon, Sparks, Md.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		C. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH <i>Coronary occlusion</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i>		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerosis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct. 6</i> , 1956, to <i>Oct. 6</i> , 1956, that I last saw the deceased alive on <i>Oct. 6</i> , 1956, and that death occurred at <i>438</i> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Parkton, Md.</i> DATE SIGNED <i>10/7/56</i>	
ACTUAL SIGNATURE <i>A. M. France</i>	PHYSICIAN'S NAME (Type) <i>A. M. France</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10-9-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>West Liberty</i>	22d. LOCATION (City, town, or county) (State) <i>White Hall, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>L. Scott Brooks</i>		ADDRESS <i>Sparks, Md.</i>	24a. REC'D BY REGISTRAR <i>9 Oct 56</i> DATE <i>9 Oct 56</i> 24b. REGISTRAR'S SIGNATURE <i>Henry Dennis Kead MacRae</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE JOURNAL OF TEACHING AND LEARNING IN THE HUMANITIES

BUREAU V.

OCT 15 1956

REGELVÉD

INSTRUCTIONS

1 Bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M -

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9989 CERTIFICATE OF DEATH

09961

33

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN)	BALTIMORE PIKESVILLE	MARYLAND LENGTH OF STAY (in this place) 6 weeks	STATE LOUISIANA PARISH OF ORLEANS CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN NEW ORLEANS STREET ADDRESS (If rural give location) 51x-3
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) RUTH (Middle) DUFFY (Last) BARR		October 17, 1956	
5. SEX Female	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH August 26, 1892
9. AGE first birthday 64 yrs.	10. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) New Orleans, Louisiana	12. CITIZEN OF WHAT COUNTRY? United States
13. FATHER'S NAME Andrew J. Duffy	14. MOTHER'S MAIDEN NAME Lucy B. Duffy		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No	16. SOCIAL SECURITY NO. —	17. INFORMANT & ADDRESS David N. Barr, Jr. 706 Sudbrook Rd.	Pikesville, 8, Md
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
151x IMMEDIATE CAUSE Diseases or conditions, if any, giving rise to the above cause stated underlying cause last.	DUE TO (A) Carcinomatosis, extension into lungs (B) Carcinoma of the stomach with metastasis (C) —	INTERVAL BETWEEN ONSET AND DEATH 2 months 2 months	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION August 2, 1956	19b. MAJOR FINDINGS OF OPERATION Carcinoma of the stomach with metastasis	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) —	21c. WHERE DID INJURY OCCUR? (City or town) —	(County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? —	
22. I hereby certify that I attended the deceased from Sept. 15, 1956, to October 17, 1956, that I last saw the deceased alive on October 17, 1956, and that death occurred at 9:00 P.M. from the causes and on the date stated above.			
SIGNATURE <i>Millard T. Rabal J.</i>		ADDRESS (Street, city, town, state) M.D. 5101 Gwynn Oak Ave. Baltimore, 7, Md.	DATE SIGNED 10/18/56
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Oct 22, '56	NAME OF CEMETERY OR CREMATORIUM New Orleans	LOCATION (City, town, or county) Louisiana
24. REC'D BY REGISTRAR Mary B. Elme	REGISTRAR'S SIGNATURE Mary B. Elme	25. FUNERAL DIRECTOR'S SIGNATURE Amy Berryman + Sons Reston, Md	
DATE 10-19-56		ADDRESS	

BY COMMUNIST-IRANIAN STATE SECRETARY

STAGE 40-STRATEGIC PLANS

CONFIDENTIAL INFORMATION SOURCE CODED CAVO

REF ID: A61411

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BUREAU V.

OCT 22 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9990

CERTIFICATE OF DEATH

09962
34

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) D. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 19 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 451 Watty Court	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ALBERT	Middle C.	Last BATTY	4. DATE OF DEATH	Month October	Day 5	Year 1956
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 12, 1891		9. AGE (In years (last birthday) yrs. 65	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Office Building		11. BIRTHPLACE (State or foreign country) Richmond, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Batty				14. MOTHER'S MAIDEN NAME Besty MN: Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 216-03-8584		17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X CARCINOMA OF THE SIGMOID WITH METASTASIS TO XVUGO THE LIVER				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	20f. (City or town) VA	(County)	(State)		
21. I certify that I attended the deceased from September 16956 , to October 5, 1956 , VA , from the causes and on the date stated above. and that death occurred at 5:37A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND							
DATE SIGNED 10/5/56							
ACTUAL SIGNATURE Donald D. Mark, M.D.							
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-56		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law ADDRESS Charles R. Law Mortuary, 802-04 Madison Ave.							
24a. REC'D BY REGISTRAR DET 8 1956 24b. REGISTRAR'S SIGNATURE Tolson L. Farber							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 To the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - BIRTHING 18

CERTIFICATE OF DEATH

MAY 1956

BUREAU Y.

JCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09963

Reg. Dist. No.

9991

CERTIFICATE OF DEATH

44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 3 hrs 45 mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3665 Chestnut Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First THOMAS	Middle C	Last BAUBLITZ	4. DATE OF DEATH October 14 1956	Month October	Day 14	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/1900	9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months 56	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sewing Machine Adjuster		10b. KIND OF BUSINESS OR INDUSTRY Sewing Machine Mfg. Maryland (Carroll Co.)		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Baublitz		14. MOTHER'S MAIDEN NAME Alice Eberg					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214-14-6093		17. INFORMANT Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO CORONARY THROMBOSIS						INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerosis, generalized						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 4:20 PM		20f. (City or town) 8:05 PM	
						(County) (State)	
21. I certify that I attended the deceased from October 14 1956 , to October 14 1956 , and that death occurred at 8:05 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE C. J. Papasrat, M.D.		M.D.		Veterans Administration Hospital 10/15/56			
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.				Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-18-56		22c. NAME OF CEMETERY OR CREMATORIUM Moreland Memorial Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Schenck Jr.		ADDRESS Chesapeake Funeral Home 3615 Chestnut Ave., Baltimore		24a. REC'D BY REGISTRAR DATE 17 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Farley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9992

CERTIFICATE OF DEATH

09964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md.		c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00		d. STREET ADDRESS 1400 Railroad Ave				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) William		First	Middle	Last	4. DATE OF DEATH October 10, 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 27, 1888	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Employed		10b. KIND OF BUSINESS OR INDUSTRY Fire Extinguisher		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME John F. Bell		14. MOTHER'S MAIDEN NAME Laura Phillips.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Maggie Bell, 1400 Railroad Ave.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) coronary thrombosis DUE TO (c) arteriosclerotic cardiovascular disease						INTERVAL BETWEEN ONSET AND DEATH 1 hour		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						} several hours		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md
21. I certify that I attended the deceased from October 10, 1956 , to October 10, 1956 , that I last saw the deceased alive on October 10, 1956 , and that death occurred at 3:30 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 1707 Cedar Street, Lutherville, Maryland		DATE SIGNED Oct. 11, 1956		
ACTUAL SIGNATURE J. Jones A. Jacobs		PHYSICIAN'S NAME (Type) M.D.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 13/56	22c. NAME OF CEMETERY OR CREMATORIAL Satvers		22d. LOCATION (City, town, or county) Baltimore Co., Md		(State) Md		
23. FUNERAL DIRECTOR'S SIGNATURE Austin E. Donovan - 3818 Roland Ave		ADDRESS 151956		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE Anne McRee		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please return to the funeral director.

The registrar price of burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

JULY 1958

BUREAU V. S.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9971 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09965

Reg. Dist. No.

41

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 37 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 61 AVALON AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		First A.	Middle BENSON
4. DATE OF DEATH OCT 5 1956		Last BENSON	Month OCT
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH JUNE 30-1900	
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Month Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHECER		10b. KIND OF BUSINESS OR INDUSTRY SHIP YARD	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME BENSON		14. MOTHER'S MAIDEN NAME ANNE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-07-6007	
		17. INFORMANT MRS HAZEL BENSON	
		Address 3541 MERIDIAN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH —	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Obesity Occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) —		DUE TO —	
(c) —			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) — (County) — (State) —	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED 10/9/56-	
ACTUAL SIGNATURE M.B.Davis M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) M.B.DAVIS M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL OCT 9 1956		22b. DATE THEREOF OCT 9 1956	
22c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN		22d. LOCATION (City, town, or county) COLGATE MD	
23. FUNERAL DIRECTOR'S SIGNATURE ULLRICH FUNERAL HOME 2112 DUNDEA		24a. REC'D BY REGISTRAR DATE 10 1956	
ADDRESS —		24b. REGISTRAR'S SIGNATURE Hann P. Kelly	

RECEIVED
BUREAU V. S.
OCT 10 1956

DEPARTMENT OF HUMAN PERFORMANCE
MEDICAL & MINERS CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09966

Reg. Dist. No. 38

9993

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Putty Hill		c. LENGTH OF STAY IN 1b 79 mos.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10041 Harford Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Johanna	Middle D.	Last Blacklock		
4. DATE OF DEATH	Month October	Day 22,	Year 1956		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 23, 1873		
		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) yrs. 83		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home			
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME William Gerke		14. MOTHER'S MAIDEN NAME Louise Cruse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None			
17. INFORMANT Josiah A. Blacklock		Address 1600 Walterswood Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Scleriosis Coronary					
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arteriosclerosis generalized					
DUE TO					
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from For about 19 years alive on Oct. 27, 1956, and that death occurred at _____ M, from the causes and on the date stated above.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ADDRESS (Street, city or town, state) Louis N. Reedin M.D. 5901 Ayleshire Road Baltimore 12, Md.				DATE SIGNED	
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 24, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Waugh Chapel	
22d. LOCATION (City, town, or county) Balto. Co. Md.				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE OCT 25 1956	
				24b. REGISTRAR'S SIGNATURE Dr. A. M. Bacons	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

CERTIFICATE OF DATE

BUREAU V. 3

OCT 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09967

9994

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	c. LENGTH OF STAY IN 1b <u>6424 Liberty Road</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>Pikesville</u> <u>6424 Liberty Road</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>6424 Liberty Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>JOSEPH</u>	First <u>Male</u>	Middle <u>B</u>	Last <u>HASS</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Forman</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing</u>	11. BIRTHPLACE (State or foreign country) <u>Russia</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Wolf</u>	14. MOTHER'S MAIDEN NAME <u>Basheva</u>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sarah Glass - same</u>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>7 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) M.D.	(County) (State)
21. I certify that I attended the deceased from <u>2 Apr</u> , 19 <u>54</u> , to <u>13 Oct</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11 Oct</u> , 19 <u>55</u> , and that death occurred at <u>111 M</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Mary D. Van</u> ADDRESS (Street, city or town, state) <u>3601 Park Ave</u> DATE SIGNED <u>10/14/56</u> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10-15-1956</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Washington Re</u>	22d. LOCATION (City, town, or county) <u>Baltimore MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jac Louis Inc- 2100 Eutaw Place</u>		ADDRESS <u>10-15-1956</u>	24a. REC'D BY REGISTRAR DATE <u>Dorothy Newell</u>
VS A15 (4) 15M 9/55		24b. REGISTRAR'S SIGNATURE	

MAGAZINE STATE OF HAWAII—GETTING IT

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP CODE

PHONE

FAX

TELE

E-MAIL

TELE

FAX

TELE

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09968

9995 CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the regular within 72 hours after death. After this bottom copy has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate should be detached for use as a burial transit permit.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Baltimore Maryland Catonsville	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Md. Balto. Catonsville
LENGTH OF STAY (In this place)		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Holmehurst Ave.		16 Holmehurst Ave.	
3. NAME OF DECEASED (First) Herbert (Middle) B. (Last) Bohanan		4. DATE OF DEATH Oct. 2 1956	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH April 7, 1879
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop. Ret.		10b. KIND OF BUSINESS OR INDUSTRY Grocery	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME Charles M. Bohanan		14. MOTHER'S MAIDEN NAME Laura Pursel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) -		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS Rev. T.M. Bohanan 16 Holmehurst	
18. MEDICAL CERTIFICATION			
<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>420.1 IMMEDIATE CAUSE (A) Coronary Embolism ANTECEDENT CAUSE(S) DUE TO Cardio-Vascular Renal Disease DISEASES OR CONDITIONS, IF ANY, (B) 7 41-5 GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C) Emphysema</p> <p>INTERVAL BETWEEN ONSET AND DEATH 1 hr.</p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Nol while at work <input type="checkbox"/>	
		21f. HOW DID INJURY OCCUR?	
<p>22. I hereby certify that I attended the deceased from 8:18 AM, 19 49, to 10:20 AM, 19 56, that I last saw the deceased alive on 10/1/56, and that death occurred at 11:57 AM, from the causes and on the date stated above.</p> <p>SIGNATURE <i>George E. Litman</i> ADDRESS (Street, city, town, state) <i>805 3rd Ave. 28 Md.</i> DATE SIGNED <i>10.2.56</i></p>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-8-56	NAME OF CEMETERY OR CREMATORIALoudon Park Cem.
24. REC'D. BY REGISTRAR DATE OCT 9 1956		REGISTRAR'S SIGNATURE <i>E. Harry</i>	LOCATION (City, town, or county) Balto. (State) Md.
25. FUNERAL DIRECTOR'S SIGNATURE <i>J. J. J. Funeral Home - Catonsville Md.</i>		ADDRESS	

STATE OF CALIFORNIA

CERTIFICATE OF DEATH

RECEIVED BY THE STATE OF CALIFORNIA

DEATH REGISTRATION

BUREAU V.

OCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09969

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 127 Fleming Drive	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BERNARD	Middle C	Last BOOKER	4. DATE OF DEATH Month October	Day 14	Year 1956	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 12/11/23	9. AGE (In years lost birthday) 32 yrs.	IF UNDER 1 YEAR Months 32	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Sparrows Point, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Whitley Booker				14. MOTHER'S MAIDEN NAME Theresa Booker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 220 14 1122		17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT HYPERTENSION DUE TO NEPHROSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
20c. TIME OF INJURY Month, Day, Year Hour o. g. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 6, 1956 , to October 14, 1956 . <i>Not first saw the deceased die</i> , and that death occurred at 2:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 10/14/56							
ACTUAL SIGNATURE <i>C. M. Snyder M.D.</i>		M.D.					
PHYSICIAN'S NAME (Type) C. M. SNYDER, M.D.		VAH, Fort Howard, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/56		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law Funeral Home</i>		ADDRESS 802-0 Madison Ave.		24a. REC'D BY REGISTRAR OCT 16 1956		24b. REGISTRAR'S SIGNATURE <i>Season L. Farley</i>	
VS A15 (4) 1SM 9/55							

BUREAU V.

16 1956

REGEIY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 3 should be detached, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9997

CERTIFICATE OF DEATH

09970

38

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Baltimore MARYLAND		Maryland Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Villa Nova			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Robb Nursing Home			
3. NAME OF DECEASED (Type or print)	First ELIA	Middle D.	Last BORNMANN
4. DATE OF DEATH	Month 10	Day 6	Year 19 56
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
Female	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3/11/1869
9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
87			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		11. BIRTHPLACE (State or foreign country)	
		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Hooper		?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		None	
17. INFORMANT		Address	
		Mrs. Virginia Warnsmann-4015 Villa Nova Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
451X DUE TO Gestic intestinal hemorrhage 24 hrs			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)			
DUE TO Amnesia 7			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
Atherosclerosis generalized			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 4</u> , 1956, to <u>Oct 6</u> , 1956, that I last saw the deceased alive on <u>Oct 5</u> , 1956, and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state)			
DATE SIGNED			
ACTUAL SIGNATURE <u>Lewis Dubman</u> M.D. <u>Petersville 21 Nov 1956</u>			
PHYSICIAN'S NAME (Type) <u>Lewis Dubman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56	
22c. NAME OF CEMETERY OR CREMATORIUM St. James Cemetery		22d. LOCATION (City, town, or county) My Lady's Manor, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tedder & Sons - Nancy Paques</u> Baltimore, Md.		24a. REC'D BY REGISTRAR DATE 9/18 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Mabel Grays</u>	

BUREAU V.

OCT 9 1956

REFUGEE FED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9998 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09971

Reg. Dist. No.

1
PLACE OF DEATH

a. COUNTY

Baltimore,

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Tankville

c. LENGTH OF STAY IN 1b

Transient

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Putty Hill Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Baltimore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Sparks

Phoenix

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM?

YES NO

3. NAME OF DECEASED
(Type or print)

First Courtney Middle Oliver Last Bowman

4. DATE OF DEATH

Month October
Year 1956

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

8. DATE OF BIRTH

10-11-1904

9. AGE (In years
last birthday)

81
yrs.

10. IF UNDER 1 YEAR

Months
Days

11. IF UNDER 24 HRS.

Hours
Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

handicrafts

10b. KIND OF BUSINESS OR INDUSTRY

Metropolitan Dis.
Balto. County

11. BIRTHPLACE (State or foreign country)

Kentucky

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Wm. T. Bowman

14. MOTHER'S MAIDEN NAME

?

Lawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
If yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

215-16-1879

17. INFORMANT

Ada W. Bowman

Address

Phoenix, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

Myocardial Deterioration

INTERVAL BETWEEN
ONSET AND DEATH

2-3 minutes

DUE TO

(b)

Advanced Generalized Arteriosclerosis

under

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED?

YES NO

20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING

CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY

Month, Day, Year

Hour

a. m.

p. m.

19

20d. INJURY OCCURRED

While
at work

Not while
at work

20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes Accident , Suicide , Homicide , Undetermined cause

ACTUAL
SIGNATURE

John C. Hyle

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

10-10-56

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Burial

10-13-56

Poplar Grove

Cockeysville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Sparks, Md.

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

DATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

1
 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to removal.

V.S. A15ME(S)
SM 9/55

MARSHAL LAW STATUS DETERMINATION OF BAGHDAD - BAGHDAD, 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

OCT 16 1956

RECEIVED

INSTRUCTIONS

ATTENDEE'S PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this bottom copy has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09972

32

CERTIFICATE OF DEATH

Reg. Dist. No.....

9999

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) TOWN Stevenson		MARYLAND LENGTH OF STAY (In this place) STREET ADDRESS Villa Julie Valley Rd.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Villa Julie		STATE Md CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Stevenson (If rural give location)	
3. NAME OF DECEASED (Type or Print) Sister Paulina (Elizabeth Brady)		4. DATE OF DEATH Oct. 15 1956	
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Nov. 12, 1878 9. AGE last birthday 77 yrs.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tescher		10b. KIND OF BUSINESS OR INDUSTRY Religious	11. BIRTHPLACE (State or foreign country) Kentucky
13. FATHER'S NAME Thomas Brady		14. MOTHER'S MAIDEN NAME Bebiana Vale	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) --		16. SOCIAL SECURITY NO. --	
17. INFORMANT & ADDRESS Sister Marie Dolores Villa Julie		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4221 IMMEDIATE CAUSE (A) Congestive heart failure ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) Arteriosclerotic Cardiovascular disease GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 1954</u> to <u>Oct. 15, 1956</u> , that I last saw the deceased alive on <u>Oct. 14, 1956</u> , and that death occurred at <u>12:18 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Harold H Burns</u>		ADDRESS (Street, city, town, state) <u>115 E. Eager St.</u> DATE SIGNED <u>10-16-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10-17-56 NAME OF CEMETERY OR CREMATORIAL Trinity Convent Cem. LOCATION (City, town, or county) Ilchester (State)	
24. REC'D BY REGISTRAR DATE SCT 17 1956		REGISTRAR'S SIGNATURE <u>Dorothy Newell</u> 25. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home, Catonsville, Md.</u> ADDRESS d.	

STATE OF NEW YORK - DEPARTMENT OF STATE - ALBANY

CERTIFICATE OF DEATH

DEATH CERTIFICATE

DEATH
DATE
MATERIAL

DEATH
PLACE

DEATH
TIME

DEATH CERTIFICATE

BUREAU V.

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0997338

10000

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Balto.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Brooklandville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION <i>Green Spring Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First <i>GEORGE</i>	Middle <i>Brown Jr</i>	Last Month Day Year <i>Oct 7 1956</i>	
4. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 5 1880</i>	
9. AGE (In years lost birthday) yrs. <i>76</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>BANKER</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	11. BIRTHPLACE (State or foreign country) <i>Balto Md</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	13. FATHER'S NAME <i>George Brown</i>			
14. MOTHER'S MAIDEN NAME <i>Frances Winchester</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>			
16. SOCIAL SECURITY NO. <i>-</i>			17. INFORMANT <i>Mr. Gary Black Stevenson Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>156.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>Carcinoma - Liver</i>			INTERVAL BETWEEN ONSET AND DEATH <i>3 mo?</i>	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month <i>June</i>	Day <i>19</i>	Year <i>1956</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Balto</i>	(County) <i>Md</i>	(State) <i>Md</i>	
21. I certify that I attended the deceased from <i>June 1956</i> to <i>Oct 7 1956</i> that I last saw the deceased alive on <i>Oct 7 1956</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.			ADDRESS (Street, city or town, state) <i>1101 St Paul St</i>	DATE SIGNED <i>Walter A Baetjer</i>
ACTUAL SIGNATURE <i>Walter A Baetjer</i>	PHYSICIAN'S NAME (Type) <i>WALTER A BAETJER</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		
22b. DATE THEREOF <i>10-9-56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Green Mount</i>	22d. LOCATION (City, town, or county) <i>Balto</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins Amico 4905 York Rd</i>	ADDRESS <i>9518 1956</i>	24a. REC'D BY REGISTRAR DATE <i>Mal Grays</i>	24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician and complete filled in by funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation or removal, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - SEATTLE

CERTIFICATE OF DEATH

1956

1956

BUREAU Y. S.

OCT 9 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09974

10001 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard, Md.		c. LENGTH OF STAY IN 1b 93 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland		d. STREET ADDRESS 1307 Ensor Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First IVAN	Middle P.	Last BRYANT	4. DATE OF DEATH October 21 1956	Month October	Day 21	Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH September 2, 1895	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Construction		10b. KIND OF BUSINESS OR INDUSTRY Maryland State		11. BIRTHPLACE (State or foreign country) Middle-Sex, North Carolina U.S.A.		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Joe Bryant				14. MOTHER'S MAIDEN NAME Elthonia Madeling					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI 220-07-5960		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 160X		DUE TO SQUAMOUS CELL CARCINOMA OF LEFT MAXILLARY ANTRUM		INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO BRONCHOPNEUMONIA, BILATERAL		UNKNOWN					
(c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. VA		Month a. m.	Day 19	Year p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH, FORT HOWARD, MARYLAND	(County) MARYLAND	(State) MARYLAND
21. I certify that I attended the deceased from July 20, 1956 , to October 21, 1956 , and that death occurred at 10:05 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND							
ACTUAL SIGNATURE C. J. Papastrat, M.D.		DATE SIGNED 10/22/56							
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.									
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-56	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National			22d. LOCATION (City, town, or county) Baltimore, Maryland			(State) MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE Wm Cook Blight Inc.		ADDRESS 6009 Harford Rd. Balto. Md.			24a. REC'D BY REGISTRAR JULY 30 1956		24b. REGISTRAR'S SIGNATURE Lawson L. Farber		

81.3000148-872214-0-DEPARTMENTAL CIRCUITS

SUREAU V. S.

956 SO 130

REGEIY ED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG205 10-26-56 et

09975
45

10002

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>7920 Bridge Ave.</i>		b. COUNTY	
c. LENGTH OF STAY IN 1b <i>Chesaco Pk.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>7920 Bride. Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Frank</i>		First	Middle
		Last	<i>Bubczyk</i>
4. DATE OF DEATH <i>Oct. 17, 1956</i>		Month	Day
		Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 1887</i>
		9. AGE (in years lost birthday) <i>69 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>G. Bubczyk</i>		14. MOTHER'S MAIDEN NAME <i>Mary Bubczyk</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>(If yes, give war or dates of service)</i>	
17. INFORMANT <i>Mary Bubczyk Wife</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Miliary tuberculosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
DUE TO <i>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</i>			
(b) DUE TO <i>Pulmonary tuberculosis</i>		10 years	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>April 1952</i> to <i>Oct. 1956</i> , that I last saw the deceased alive on <i>Oct. 17, 1956</i> , and that death occurred at <i>10:15 p.m.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>8019 Philadelphia Rd.</i>	
ACTUAL SIGNATURE <i>James R. Mason, M. D.</i>		DATE SIGNED <i>10-18-56</i>	
PHYSICIAN'S NAME (Type) <i>James R. Mason, M. D.</i>		Baltimore 6. Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 15/56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Rosary</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Fred W. Ozazewski</i>		ADDRESS <i>1930 Eastern Ave.</i>	24a. RECD BY REGISTRAR <i>Oct. 17, 1956</i>
			24b. REGISTRAR'S SIGNATURE <i>Mrs. Edith Starkey</i>

MAXWELL STATE DEPARTMENT OF HEALTH - BIRMINGHAM 10

CERTIFICATE OF DEATH

BUREAU Y. S.

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09976

44

10003

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-trust permit. Then please remove carbon papers. **Form 3** should be detached prior to burial, cremation, or removal, and in event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN lb 14 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		3 YO 1-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 2215 PULASKI STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First CORNELL	Middle J.	Last BULLOCK	4. DATE OF DEATH	Month OCTOBER	Day 21,	Year 1956	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2-17-09	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MESSENDER		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL		11. BIRTHPLACE (State or foreign country) NORFOLK, VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME THOMAS BULLOCK				14. MOTHER'S MAIDEN NAME LUCET HENDERSON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> YES		16. SOCIAL SECURITY NO. WW-11		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA				INTERVAL BETWEEN ONSET AND DEATH 1 MONTH				
445X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) MALIGNANT HYPERTENSION				6 MONTHS				
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) PARALYTIC ILEUS - Duration, 6 Days				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. n. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH, FORT HOWARD, MARYLAND	(County) 10-21-56	(State) MD.			
21. I certify that I attended the deceased from Oct. 7, 1956, to Oct. 21, 1956, at VAH, FORT HOWARD, MARYLAND , and that death occurred at 3:10 A.M., from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Armen Bogosian</i>				ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10-21-56				
PHYSICIAN'S NAME (Type) ARMEN BOGOSSIAN		M.D. VAH, FORT HOWARD, Maryland 10-21-56						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-21-56	22c. NAME OF CEMETERY OR CREMATORIAL BALTIMORE NATIONAL	22d. LOCATION (City, town, or county) BALTIMORE MARYLAND	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips, 1808 N. Monroe St., Baltimore, Md.		ADDRESS DATE Oct 25 1956	24a. REC'D BY REGISTRAR Dawson L. Taylor	24b. REGISTRAR'S SIGNATURE				

MATERIALS STATE DOCUMENT OF REVENGE-SATINAGE-18

CERTIFICATE OF DEATH

DEATH CERTIFICATE

BUREAU V. S

OCT 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09977

10004

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL
OR ~~and give nearest town~~
TOWN North Point VillageLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS 7922 St. Clare Lane3. NAME OF
DECEASED:
(Type or Print)

MARY

(First) (Middle)
SOPHIA(Last)
CARLIN4. SEX: 6. COLOR OR
RACE:
Female White7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify) Married

8. DATE OF BIRTH: Nov. 18, 1885

9. AGE last birthday
70 yrs.IF UNDER 1 YEAR
Months Days
Hours Min.10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired) House Work10B. KIND OF BUSINESS
OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country):

Baltimore, Md.

12. CITIZEN OF WHAT
COUNTRY?
U.S.A.

13. FATHER'S NAME:

Adam Hock

14. MOTHER'S MAIDEN NAME:

Margaret Schindhelm

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates
of service) No16. SOCIAL SECURITY NO.
NoneINTERVAL BETWEEN
ONSET AND DEATH18. MEDICAL CERTIFICATION
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

IMMEDIATE CAUSE

(A)
DUE TO

Congestive Heart Failure

14 days.

ANTECEDENT CAUSE (S):

(B)
DUE TO

Arteriosclerotic Heart Dis.

30 years.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO 21A. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town) (County)
INJURY OCCUR?21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
While Not while
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 29, 1956, to Oct. 30, 1956, that I last saw the deceased
alive on Oct. 29, 1956, and that death occurred at 7:55 A.M. on the causes and on the date stated above.
ADDRESS: DATE SIGNED
Signature: M.D. 520 35th St. 10/31/6623. BURIAL, CREMATION,
REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

Signature: Charles J. Balto., MD.

520 D St.
Roseville, Calif.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09978

10005

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 1 Day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 103 Warren Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR, INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First THOMAS	Middle J.	Last CHAMBERS	4. DATE OF DEATH	Month October	Day 24	Year 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH November 20, 1892	9. AGE (In years (last birthday) yrs. 63	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Manufacturing Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Charles C. Chambers				14. MOTHER'S MAIDEN NAME Bridgett MN: Stapleton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-05-4941		17. INFORMANT Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		ARTERIOSCLEROTIC HEART DISEASE WITH AORTIC XKG6 STENOSIS				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO		(b) (c)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH	(County)	(State)
21. I certify that I attended the deceased from October 23, 1956 , to October 24, 1956 , and that death occurred at 11:45 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>C. J. Papastrat M.D.</i>		ADDRESS (Street, city or town, state)		DATE SIGNED 10/25/56				
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-29-56	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland			(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Cook Blight, Inc.</i>		ADDRESS Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.		24a. REC'D BY REGISTRAR REC'D 30/10/56		24b. REGISTRAR'S SIGNATURE <i>Elmer L. Farley</i>		

THE 1997 PROVINCIAL ELECTION IN THE TRADITIONAL STATE OF MEXICO

BUREAU V. S.

OCT SC 1956

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09979

Reg. Dist. No. 44

10006

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 101 Days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle W.	Last CHANAY	4. DATE OF DEATH October 22	Month Day Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 4, 1888	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tree Trimmer Laborer		10b. KIND OF BUSINESS OR INDUSTRY Tree Trimmer		11. BIRTHPLACE (State or foreign country) Savage, Maryland	
13. FATHER'S NAME Samuel Chaney		14. MOTHER'S MAIDEN NAME Frances Tucker		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes	16. SOCIAL SECURITY NO. 220-01-2640	17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		CEREBRAL THROMBOSIS			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		ARTERIOSCLEROTIC HEART DISEASE			
(c)		UNKNOWN			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 13, 1956 , to October 22, 1956 , and that death occurred at 8:30 P.M. from the causes and on the date stated above.					
ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE <i>C. J. Papastrat MD</i>					
M.D. VAH, FORT HOWARD, MARYLAND 10/23/56					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-26-56	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Cook-Bright, Inc.</i>	ADDRESS 6009 Harford Road	24a. REC'D BY REGISTRAR DATE 30 1956		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farley</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove coupon papers, pages 1 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ST. EMMANUEL - MELAKA RO 98-ATRA003 STATE OWNERSHIP

UREAU V.

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REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09980

44

10007

CERTIFICATE OF DEATH

Reg. Dist. No.

~~TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.~~

~~TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.~~

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3312 Chestnut Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JEROME		First	Middle E	Lost	4. DATE OF DEATH Month October	Day 15	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/2/96		9. AGE (In years lost birthday) yrs. 60	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal Mfgs.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Sylvester Charters				14. MOTHER'S MAIDEN NAME Lena Fludung			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> VWI		16. SOCIAL SECURITY NO. 216-09-8418		17. INFORMANT Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS, LEFT MIDDLE CEREBRAL ARTERY				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
Generalized Arteriosclerosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 12, 1956 , to October 15, 1956 , that death occurred in the above stated time and place, and that death occurred at 7:40 P.M. , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE C. J. PAPASTRAT MD. M.D. Veterans Administration Hospital 10/16/56							
DATE SIGNED							
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.		Fort Howard, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19, 1956		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS Horace E. Burgee, Jr. 3631 Falls Rd., Balto., Md.		24a. REC'D BY REGISTRAR Oct. 17, 1956		24b. REGISTRAR'S SIGNATURE Dewson L. Farley	

STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

REG. NO. 10

100-00

DEATH

8003

DEPT. OF PUBLIC WELFARE

NAME OF DECEASED: MARY E. BURKE

ADDRESS: 1015 E. 36TH ST., BALTIMORE 18

AGE: 60 yrs.

SEX: FEMALE

MARITAL STATUS: MARRIED

EDUCATION: GRAVES

RELIGION: CATHOLIC

EMPLOYMENT: HOUSEWIFE

DEATH OCCURRED: 10/18/56

TIME OF DEATH: 10:00 P.M.

CAUSE OF DEATH: HEART DISEASE

PLACE OF DEATH: HOME

DEATH CERTIFIED BY: DR. JAMES J. O'LEARY

BUREAU OF V. S.

OCT 18 1956

RECEIVED

INSTRUCTIONS

ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09981

CERTIFICATE OF DEATH

Reg. Dist. No.

10008

1. PLACE OF DEATH

COUNTY

BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)

TOWN COCKEYSVILLE

LENGTH OF STAY
(In this place)

19 YEARS

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

MASONIC HOME

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MD

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

BALTIMORE

3101-4

STREET
ADDRESS

2502 N. CALVERT ST.

3. NAME OF
DECEASED
(Type or Print)

(First) GERTRUDE

(Middle) MAY

(Last) CLARKE

4. DATE
OF
DEATH

Oct. 9

1956

5. SEX

F

6. COLOR OR
RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify) WIDOW

8. DATE OF BIRTH

10/20/1872

9. AGE last birthday

83

IF UNDER 1 YEAR
MonthsIF UNDER 24 HRS.
Days

Hours

Min.

10d. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired) HOUSEWIFE10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

PENNA.

12. CITIZEN OF WHAT
COUNTRY

US

13. FATHER'S NAME

THEODORE MONTGOMERY

14. MOTHER'S MAIDEN NAME

HARRIET DUBOSS

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT & ADDRESS

Paul L. Smith Jr.
Cockeysville, Md.INTERVAL BETWEEN
ONSET AND DEATH

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE

(A)

Arterio-Sclerotic Cardio

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

DUE TO

Vascular disease

3 years

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

2d. AUTOPSY?

YES NO 21a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21a. INJURY OCCURRED
M. While at work Not while at work

21f. HOW DID INJURY OCCUR?

M. at work

22. I hereby certify that I attended the deceased from.....

alive on.....

8/17 1950 to 10/18 1956, and that death occurred at 11 P.M., from the causes and on the date stated above.

SIGNATURE

Walter J. Kies

ADDRESS (Street, city, town, state)

DATE SIGNED

10/9/56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

BURIAL

DATE THEREOF

10-12-56

NAME OF CEMETERY OR CREMATORI

Green Mount

LOCATION (City, town, or county)

Balto Md

(State)

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

Frank Smith

25. FUNERAL DIRECTOR'S SIGNATURE

Wm Cook

ADDRESS

1417 St. Paul St.

DATE

OCT 11 1956

BY REGIMENTAL NUMBER TO THE STATE GUARD

CERTIFICATE OF DEATH

REGIMENTAL NUMBER

NAME OF DECEASED

REGIMENTAL NUMBER

DATE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RELATIONSHIP

DEATH CERTIFICATE

REGIMENTAL NUMBER

NAME OF DECEASED

DATE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

RELATIONSHIP

BUREAU V. S.

OCT. 11 1956

REGIMENTAL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1809982
10009 CERTIFICATE OF DEATH

Reg. Dist. No. 11

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville		c. LENGTH OF STAY IN lb 8 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pikesville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 726 Howard Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Myrtle		First Lee	Middle Cohee	Last Cohee	4. DATE OF DEATH October 24, 1956	Month October	Day 24	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 17, 1875	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel K. Gootee				14. MOTHER'S MAIDEN NAME Anna R. Griffith				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Louise Draper, 726 Howard Rd.		Address Pikesville		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Breast						INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		
170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)								
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Caroline County, Md.	(County)	(State)
21. I certify that I attended the deceased from Aug. 1951 to Oct. 24, 1956 , that I last saw the deceased alive on October 24, 1956 , and that death occurred at 11:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1331 Reisterstown Rd, Pikesville, Md. DATE SIGNED 10/27/56								
ACTUAL SIGNATURE <i>James A. Miller M.D.</i>	PHYSICIAN'S NAME (Type) James A. Miller M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 27, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Concord Cemetery		22d. LOCATION (City, town, or county) Caroline County, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Vangie Mooreson</i>		ADDRESS <i>Portion, Md.</i>	24a. REC'D BY REGISTRAR DATE 10/27/56		24b. REGISTRAR'S SIGNATURE <i>Sam D. George</i> <i>Dorothy Merleba</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE DEPARTMENT OF HEALTH - ALASKA
CERTIFICATE OF DEATH

REGELIVE

OCT 29 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10010

CERTIFICATE OF DEATH

09983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 66 Days		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. STREET ADDRESS 1413 Lemmon Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM		First H.	Middle COOK	Last October	4. DATE OF DEATH Month 14 Day 19 Year 56
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/97	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Seed Company		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Jerry Cook		14. MOTHER'S MAIDEN NAME Hester Scipio		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217 03 9983		17. INFORMANT Address Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		SQUAMOUS CELL CARCINOMA OF LEFT LUNG DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. 11 . p. m. VA		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 9 , 19 56 , to October 14 , 19 56 , that I last saw the deceased 10/14/56 , and that death occurred at 11:40A M , from the causes and on the date stated above. ACTUAL SIGNATURE C. M. Snyder M.D.		ADDRESS (Street, city or town, state) VAH, Fort Howard, Maryland DATE SIGNED 10/14/56			
PHYSICIAN'S NAME (Type) C. M. SNYDER, M.D.		VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 17 1956		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National	
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Katie Williams		ADDRESS 322 N. Schreiner St.		24a. REC'D BY REGISTRAR 17 1956	
				24b. REGISTRAR'S SIGNATURE Lawrence L. Farber	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return to the funeral director.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be detached for use as the burial-transit Permit. Then please remove carbon paper and file with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

I

Digitized by srujanika@gmail.com

CT 17 1956

REGGAE IV EDO

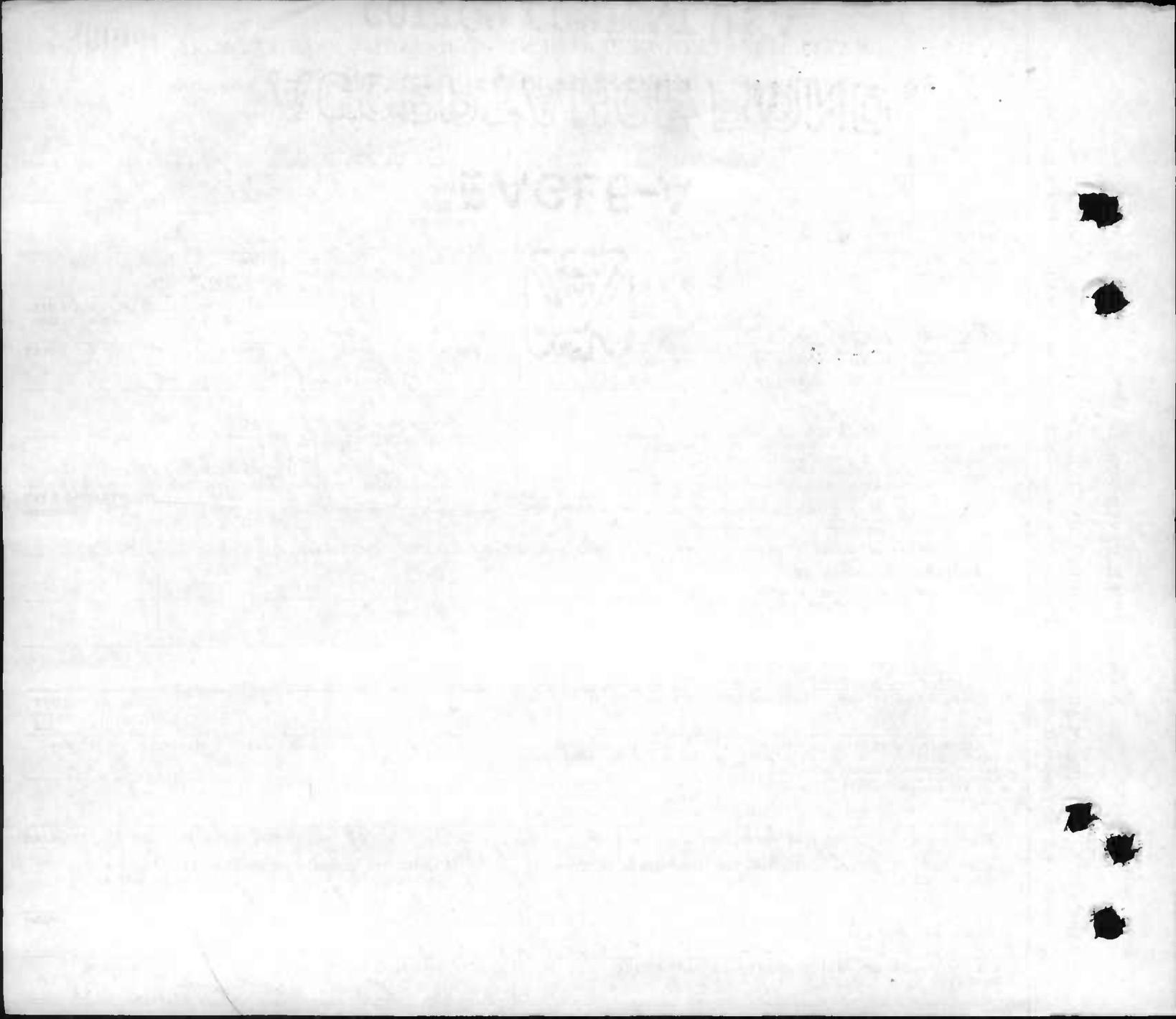
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09984
32

10011 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Pikesville</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>125 S Lade</u>		STREET ADDRESS <u>125 S Lade Ave.</u>	
3. NAME OF DECEASED: (First) <u>Bertha</u> (Middle) <u>Schaefer</u> (Last) <u>Cox</u> 4. DATE (Month) (Day) (Year) OF DEATH: <u>Oct. 4</u> <u>1966</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>MARRIED</u>	8. DATE OF BIRTH: <u>Jan. 14 1876</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>John Schaefer</u>		14. MOTHER'S MADDEN NAME: <u>Margaret Maisel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr J W Cox, 125 S Lade Ave, Pikesville</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>450.0</u> IMMEDIATE CAUSE (A) <u>Generalized arteriosclerosis</u> ANTECEDENT CAUSE (B) <u>none</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>none</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>street</u>	21C. WHERE DID (City or town) INJURY OCCUR? <u>Pikesville</u>
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>July 1956</u> to <u>4 Oct 1966</u> that I last saw the deceased alive on <u>3 Oct 1956</u> and that death occurred at <u>125 S Lade Ave</u> M, from the causes and on the date stated above. SIGNATURE <u>Paul H Royle</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-6-56</u>	NAME OF CEMETERY OR CREMATORIAL <u>Daniel Ridge</u>
DATE REC'D BY LOCAL REGISTRAR <u>10-4-56</u>		REGISTRAR'S SIGNATURE <u>L</u>	LOCATION (City, town, or county) <u>Pikesville Md.</u>
24. FUNERAL DIRECTOR		ADDRESS <u>Frank H. Neuwirth - Pikesville, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09985

38

10012

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
 Please remove carbon paper pages 1 and 2 before filing.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c: LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS 8 Aintree Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 Aintree Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LAMBERT	Middle FOSTER	Last CROMWELL	4. DATE OF DEATH	Month Oct.	Day 29	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1880	9. AGE (In years lost birthday) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plant Engineer - Rtd		10b. KIND OF BUSINESS OR INDUSTRY C. & P. Tel. Co.		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lambert Cromwell		14. MOTHER'S MAIDEN NAME Laura Morgan					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Winifred Cromwell - 8 Aintree Rd., Towson	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Arterio-sclerotic DUE TO 4 years (c) Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Pikesville	(County) Md.	(State) Md.
21. I certify that I attended the deceased from July 19, 1956 to 29 Oct., 1956 , that I last saw the deceased alive on 29 Oct., 1956 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Charles D. Kiser</i>	ADDRESS (Street, city or town, state) 6701 York Edgewater Md.		DATE SIGNED Nov. 1, 1956				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/56	22c. NAME OF CEMETERY OR CREMATORIAL Druide Ridge Cem.		22d. LOCATION (City, town, or county) Pikesville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. J. Richner & Sons - Baltimore, Md.</i>		ADDRESS	24a. REGD BY REGISTRAR DATE Nov. 1, 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray		

10 EROMILLAS-100 MASH-10 TERRITORY STATE DIVISION

BUREAU Y.

NOV 2 1956

REGELYÉD

MARYLAND STATE DEPARTMENT OF HEALTH

09986

2411 N. Charles Street, Baltimore

9972

CERTIFICATE OF DEATH

Reg. Dist. No.....

4. PLACE OF DEATH-

COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)

LENGTH OF STAY

(in this place)

TOWN

Dundalk, 22

23 yrs.

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

209 CENTER STREET

3. NAME OF
DECEASED
(Type or Print)

LOUIS

(Middle)

2. USUAL RESIDENCE (HOME) OF DECEASED-

STATE

Maryland

COUNTY

Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

Dundalk, 22

STREET

ADDRESS

(If rural give location)

209 CENTER STREET

1

3. NAME OF
DECEASED
(Type or Print)

LOUIS

(Middle)

(Last)

4. DATE
OF
DEATH

October

13

1956

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED
(Specify)

Married

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Truckdriver for Railroads Co.

10b. KIND OF BUSINESS OR
INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Chester, South Carolina

12. CITIZEN OF WHAT
COUNTRY?

U.S.

13. FATHER'S NAME

JIM CROSBY

14. MOTHER'S MAIDEN NAME

MARY HILL

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of
service)

No

16. SOCIAL SECURITY NO.

705-10-9516

17. INFORMANT

INETTA CROSBY

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

196X Immediate cause

Broncho-pneumonia

INTERVAL BETWEEN
ONSET AND DEATH

2 days.

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(c)

Carcinoma of Spine (L.S.)

7 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No 21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,

OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF
INJURY

INJURY OCCURRED

While at Work Not While At work m. At work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

July 10, 1956, to October 13, 1956

alive on Oct. 13, 1956

and that death occurred at 1:30 p.m.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

REG.

DATE REC'D BY LOCAL

REGISTRAR'S SIGNATURE

ADDRESS

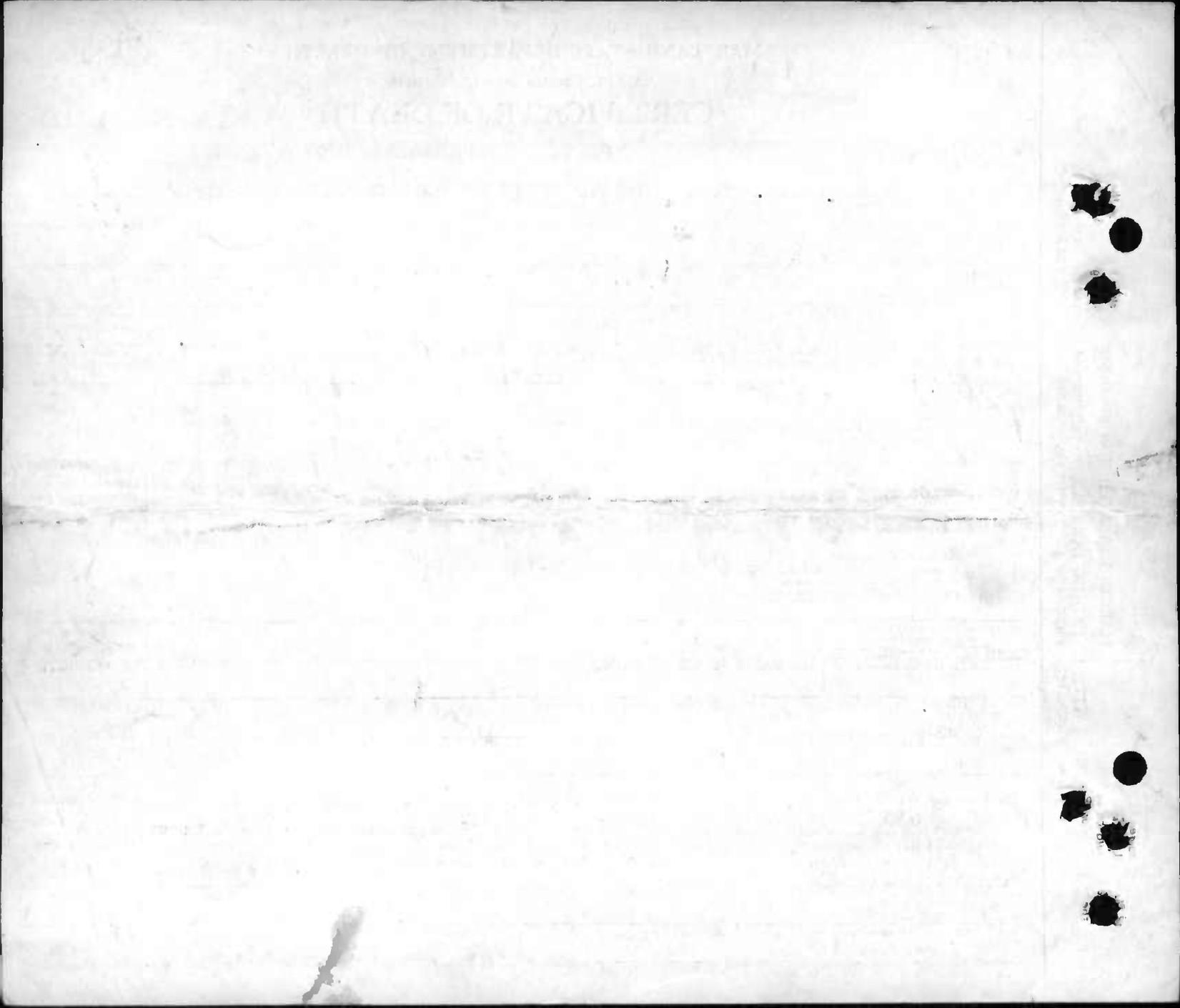
25. DATE REC'D BY LOCAL

REG.

DATE REC'D BY LOCAL

REG.

ADDRESS



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10013 CERTIFICATE OF DEATH

Reg. Dist. No. 09987 41

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) O'Donnell Hgts		c. LENGTH OF STAY IN 1b 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) O'Donnell Hgts				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6100 Shipview Ave		d. STREET ADDRESS 6100 Shipview Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Mary		First Middle Last F. Crouse		4. DATE OF DEATH Oct. 16 1956		Month Day Year		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1897	9. AGE (In years lost birthday) 59 yrs.	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Louis Simmons		14. MOTHER'S MAIDEN NAME Ida						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT John H. Crouse, 6100 Shipview Ave		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.						INTERVAL BETWEEN ONSET AND DEATH		
(b) Coronary heart disease DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause last.								
(c) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under- lying cause last.						1 wk.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. p. p. m.	Month 19	Day 19	Year	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore Co.	(State) Md.
21. I certify that I attended the deceased from Jan. 1, 1953 to Oct. 16, 1956 , that I last saw the deceased alive on Oct. 16, 1956 , and that death occurred at 8 P.M. , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 800 N. Patterson Park Ave.		
ACTUAL SIGNATURE <i>R.F. Frederick Ruzicka</i>						DATE SIGNED Oct. 22, 1956		
PHYSICIAN'S NAME (Type) Dr. F. Frederick Ruzicka								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 19/56	22c. NAME OF CEMETERY OR CREMATORIAL Oaklawn Cem.	22d. LOCATION (City, town, or county) Baltimore Co.	(State) Md.				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry H. Witte</i>		ADDRESS 4101 Edmondson Ave	24a. REC'D BY REGISTRAR OCT 22 1956	24b. REGISTRAR'S SIGNATURE <i>J. M. Kelly</i>				

CERTIFICATE OF DEATH



BUREAU V. S.
RECEIVED
OCT 22 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09988

30

10014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md.		b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		d. STREET ADDRESS 508 Lafayette Ave		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in Pines, 16 Fusting Ave				e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Margaret	Middle E.	Last Cupero	4. DATE OF DEATH Oct. 23/56	Month Oct.	Day 23	Year 1956	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Sept. 28, 1880	9. AGE (In years lost by today) 76 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Charles J. Hachtel		14. MOTHER'S MAIDEN NAME Emma Kull						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Garland Milburn, 151 E. Palisade Ave.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Parkinson's syndrome DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M.D.	(County)	(State)	
21. I certify that I attended the deceased from May 6, 1946 , to October 23, 1956 , that I last saw the deceased alive on October 23, 1956 , and that death occurred at 5:00P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4116 Edmondson Avenue DATE SIGNED 10/25/56								
ACTUAL SIGNATURE		<i>George A. Knipp, M. D.</i>						
PHYSICIAN'S NAME (Type)		<i>George A. Knipp, M. D.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 25/56	22c. NAME OF CEMETERY OR CREMATORIUM Western Cemetery	22d. LOCATION (City, town, or county) Baltimore, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry H. Withee</i>		ADDRESS 101 Edmondson Ave.	24a. REC'D BY REGISTRAR T. E. Harrys		24b. REGISTRAR'S SIGNATURE T. E. Harrys			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 3

1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, sign 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09989
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE CO.			
b. CITY OR TOWN (If outside corporate limits, write town) CATONSVILLE		c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 7			
3. NAME OF DECEASED (Type or print) SAMUEL First DARRAH Middle Last		d. STREET ADDRESS 2601 POPULAR DRIVE			
4. DATE OF DEATH Month OCTOBER Year 13 1956		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-24-70		
9. AGE (In years at birthday) yrs. 106	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during life, even if retired) SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY COAL STOVE CO.			
11. BIRTHPLACE (State or foreign country) NEW YORK		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DAVID DARAH		14. MOTHER'S MAIDEN NAME MARGARET BUSH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? UNKNOWN		16. SOCIAL SECURITY NO. 489-16-7822			
17. INFORMANT Charts SPRING GROVE STATE HOSPITAL		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary and generalized arteriosclerosis DUE TO DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 3-4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral nephrolithiasis				years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 3, 1956, to OCT. 13, 1956, that I last saw the deceased alive on OCT. 13, 1956, and that death occurred at 5:05 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Charles Ward M.D.		ADDRESS (Street, city or town, state) 10/15/56 DATE SIGNED			
PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Entombed		22b. DATE THEREOF 10/16/56		22c. NAME OF CEMETERY OR CREMATORIUM Lorraine Mausoleum	
22d. LOCATION (City, town, or county) Woodlawn, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Elsworth Armacost		ADDRESS Ellsworth Armacost-4600 Liberty Hghts. Ave.		24a. REC'D BY REGISTRAR DATE OCT 17 1956	
				24b. REGISTRAR'S SIGNATURE J. E. Harry	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED		NAME OF MEDIATOR	
JAMES LEE COOPER		JOHN W. HARRIS	
ADDRESS		ADDRESS	
111 E. 25TH ST.		111 E. 25TH ST.	
NEW YORK CITY		NEW YORK CITY	
AGE		AGE	
55		55	
SEX		SEX	
MALE		MALE	
MATERIAL TESTED		TESTS	
BLOOD		BLOOD	
TIME OF DEATH		TIME OF DEATH	
NOVEMBER 20, 1956		NOVEMBER 20, 1956	
CAUSE OF DEATH		CAUSE OF DEATH	
HYPERTENSIVE CARDIOPATHY		HYPERTENSIVE CARDIOPATHY	
TIME OF AUTOPSY		TIME OF AUTOPSY	
NOVEMBER 21, 1956		NOVEMBER 21, 1956	
SIGNATURE		SIGNATURE	
JAMES LEE COOPER		JOHN W. HARRIS	
RECEIVED		RECEIVED	
BUREAU V. S.		BUREAU V. S.	
OCT 17 1956		OCT 17 1956	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09990

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10016 Items 2, 13, 14 Film G206 11-2-56 et

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the Certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with registrar prior to removal.

VS. ATSMES(S)
SM 9/55

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Pa.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>712943-1116</i>		c. LENGTH OF STAY IN lb <i>1b</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Belair Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Russell Charles DeEsch</i>		First <i>Russell</i>	Middle <i>Charles</i>
4. DATE OF DEATH <i>OCTOBER 8 1956</i>	Month <i>OCTOBER</i>	Day <i>8</i>	Year <i>1956</i>
5. SEX <i>m</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-14-31</i>
9. AGE (In years last birthday) <i>25 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ensign</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>US Navy</i>	11. BIRTHPLACE (State or foreign country) <i>Pa</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Charles E. DeEsch</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Acker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>Currently</i>	17. INFORMANT <i>U.S. Navy</i>
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <i>Concussion & Contusive Brain injury</i> DUE TO <i>819X</i> INTERVAL BETWEEN ONSET AND DEATH <i>Just</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Head wounds & Contusional forces</i> (c) <i>Sustained in car crash.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <i>Crush injury of chest.</i>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>CAR CRASHED INTO WOOD</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>CAR CRASHED INTO WOOD</i>	
20c. TIME OF INJURY Hour <i>5:30</i>	Month, Day, Year <i>a.m. 10-8-1956</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Street</i>
20f. (City or town) <i>Kingsville</i>	(County) <i>Baltimore</i>	(State) <i>MD</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>John C. Hyde</i>	DATE SIGNED <i>10-8-56</i>		
EXAMINER'S NAME (Type) <i>JOHN C. HYDE</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	22b. DATE THEREOF <i>10-10-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>to</i>	22d. LOCATION (City, town, or county) (State) <i>Emmaus, Pa</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>HOPPING FUNERAL HOME</i>		ADDRESS <i>ANNAPOLIS, MD.</i>	24a. REC'D. BY REGISTRAR DATE <i>Oct 15 1956</i>
			24b. REGISTRAR'S SIGNATURE <i>Dr. Hellman</i>

BUREAU Y.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09991

Reg. Dist. No.

10017

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 2yr3mth15days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie, Maryland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS Box 1-Rt. 1-Agushart Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Rosina	Middle Rose	Last Diller		
4. DATE OF DEATH	Month October	Day 2,	Year 1956		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> May 26, 1864	9. AGE (in years last birthday) 92 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Germany		
13. FATHER'S NAME Emil ?		14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 902.7 Fractured left hip 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) On 9-17-56 pt. fell to floor sustaining fractured left hip.			
20c. TIME OF INJURY Hour 4:30 p.m.	Month, Day, Year Sept. 17 1956	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Catonsville, Maryland	(County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE	<i>George M. Kieffer</i>			DATE SIGNED 10-2-56	
EXAMINER'S NAME (Type)	George M. Kieffer, M. D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct 4 1956	22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery	22d. LOCATION (City, town, or county) Richie Highway	(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Dippel Brothers		ADDRESS 1800 E Lombard Street	24a. REC'D BY REGISTRAR OCT 4 1956	24b. REGISTRAR'S SIGNATURE T. E. Harrys	
VS. AISME(S) BP SM 9/55					

DEPARTMENT OF HEALTH-ENVIRONMENTAL MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

OCT 4 1956

REGISTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page
 may be relayed by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial transit permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										09992
10018 CERTIFICATE OF DEATH										Reg. Dist. No. 38
1. PLACE OF DEATH a. COUNTY Baltimore					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Md. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home 812 Register Ave.					d. STREET ADDRESS Wiltondale 309 Weatherbee Rd.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First SARAH	Middle BERTHA	Last DORSEY	4. DATE OF DEATH Oct. 5, 1956	Month Oct.	Day 5	Year 1956		
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898 Nov. 13, 1888	9. AGE (In years last birthday) 57 67	10. IF UNDER 1 YEAR Months 57	11. IF UNDER 24 HRS. Days 67	12. Hours 67	13. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary			10b. KIND OF BUSINESS OR INDUSTRY Lumber			11. BIRTHPLACE (State or foreign country) Md.				
12. CITIZEN OF WHAT COUNTRY?										
13. FATHER'S NAME George Dorsey					14. MOTHER'S MAIDEN NAME Florence Burgess					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-01-1827			17. INFORMANT Mrs. Charles A. Chrow - 309 Weatherbee Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.										Metastatic Carcinoma (Generalized) 6 months. Carcinoma of Cervix 2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Md.		20f. (City or town) Ellisott City (County) Md. (State) Md.			
21. I certify that I attended the deceased from June 1956 to October 15, 1956 , that I last saw the deceased alive on October 4, 1956 , and that death occurred at 4 PM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Charles F. O'Donnell 7501 York Rd DATE SIGNED 10/5/56
ACTUAL SIGNATURE Charles F. O'Donnell										
PHYSICIAN'S NAME (Type) Charles F. O'Donnell MD Baltimore Maryland										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/8/56		22c. NAME OF CEMETERY OR CREMATORIUM St. Johns Cem.			22d. LOCATION (City, town, or county) Ellisott City (State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Fleiner & Sons					ADDRESS Bethesda Md.					
					24a. REC'D BY REGISTRAR DATE October 6, 1956					
					24b. REGISTRAR'S SIGNATURE R. W. Malek					

СТРОМПЛАН-КОДАМ ЗО ВІДМІННО-ЗНАЧУЩИЙ

BUREAU V. S.

OCT 8 1956

PREGEIY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09993

Reg. Dist. No. 33

10019

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown		c. LENGTH OF STAY IN 1b 2 yrs. 2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Silver Cross Nursing Home		d. STREET ADDRESS 402 Random Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ANNA M. DRISCOLL		First	Middle	Last	4. DATE OF DEATH October 13-1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14 1904	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Middleburg-Maryland	
13. FATHER'S NAME William H. Myers		14. MOTHER'S MAIDEN NAME Sally L. Hahn		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Norman C. Cremer--402 Random Road	
				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy and 353.3		DUE TO Cardiac Decompensation		18 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) Chronic Myocarditis DUE TO		1 yr.	
		(c)		3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. none 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
				(20f. (City or town) none) (County) none (State) none	
21. I certify that I attended the deceased from 10-21 , 19 54 to 10-13 , 19 54 , that I last saw the deceased alive on 10-13 , 19 56 , and that death occurred at 6:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE D. D. Caples				ADDRESS (Street, city or town, state) 6 Hanover Rd.	
PHYSICIAN'S NAME (Type) D. D. Caples, M. D.				DATE SIGNED 10-17-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct: 17:1956		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.	
				22d. LOCATION (City, town, or county) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE G. B. Gilbert -		ADDRESS 1300 Eutaw Place,		24a. REC'D BY REGISTRAR Oct. 18, 1956	
				24b. REGISTRAR'S SIGNATURE Mary Elsie	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MANHATTAN STATE DEPARTMENT OF HEALTH—ALBANY 18

BUREAU V. S.

OCT 19 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-trust permit. Then please remove carbon paper, and in any event within 72 hours after death, the registrar prior to burial, cremation, or removal, should be filed with

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09994

CERTIFICATE OF DEATH

Reg. Dist. No.

37

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE New York		b. COUNTY 69X3		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New York City (formerly of)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION College Manor				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First LETIA	Middle THORNTON	Last DUDLEY	4. DATE OF DEATH	Month Oct.	Day 17	Year 1956	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1882	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months 74	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Peter Dudley				14. MOTHER'S MAIDEN NAME Mary Shaw				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 090-09-6602		17. INFORMANT Mr. Dudley H. Grape - 7303 Yorktown Drive		Address Towson		
18. CAUSE OF DEATH [Enter only one cause per line, for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 151X DUE TO <i>Carcinoma of the stomach</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH 6 mos.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebral hemorrhage Hemiplegia								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) falling from a chair						
20c. TIME OF INJURY Hour o. p. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) None	(County) None	(State) None
21. I certify that I attended the deceased from Nov. 1955 , to Oct 17, 1956 , that I last saw the deceased alive on Oct 16, 1956 , and that death occurred at 12 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) None								
DATE SIGNED William F Pearce M.D.								
ACTUAL SIGNATURE William F Pearce								
PHYSICIAN'S NAME (Type) WILLIAM F PEARCE 2105 N. Charles St.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10/19/56	22c. NAME OF CEMETERY OR CREMATORIUM Spring Grove Cem.		22d. LOCATION (City, town, or county) Cincinnati, Ohio				
23. FUNERAL DIRECTOR'S SIGNATURE Wm J. Dickner & Sons - Balt. 17. Md.	ADDRESS None	24a. REC'D BY REGISTRAR DATE Oct 22 1956		24b. REGISTRAR'S SIGNATURE One MacRae				

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RECEIVED **BUREAU V.S.**
OCT 22 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10021

CERTIFICATE OF DEATH

09995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 24 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 114 Linhigh Avenue, Baltimore																			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 114 Linhigh Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print)	First ERNEST	Middle 	Last DURLING	4. DATE OF DEATH October	Month 1	Day 19	Year 56																
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH September 29, 1892	9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Air Craft		11. BIRTHPLACE (State or foreign country) Milford, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.																	
13. FATHER'S NAME John Durling				14. MOTHER'S MAIDEN NAME Esther Silcox																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WW-I				16. SOCIAL SECURITY NO. 169-14-3245		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1"> <tr> <td colspan="2">PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</td> <td colspan="2">EMPYEMA, RIGHT</td> <td>INTERVAL BETWEEN ONSET AND DEATH 1 WEEK</td> </tr> <tr> <td colspan="2">DUE TO ABSCESS, RIGHT LOWER LOBE</td> <td colspan="2"></td> <td>UNKNOWN</td> </tr> <tr> <td colspan="2">Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Myocardial infarction</td> <td colspan="2">DUE TO INFARCTION, RIGHT LOWER LOBE</td> <td>UNKNOWN</td> </tr> </table>									PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		EMPYEMA, RIGHT		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	DUE TO ABSCESS, RIGHT LOWER LOBE				UNKNOWN	Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Myocardial infarction		DUE TO INFARCTION, RIGHT LOWER LOBE		UNKNOWN
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		EMPYEMA, RIGHT		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK																			
DUE TO ABSCESS, RIGHT LOWER LOBE				UNKNOWN																			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Myocardial infarction		DUE TO INFARCTION, RIGHT LOWER LOBE		UNKNOWN																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial infarction due to arteriosclerotic coronary thrombosis duration unknown																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)																
21. I certify that I attended the deceased from September 7, 1956 , to October 1, 1956 , and that death occurred at 12:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND																							
ACTUAL SIGNATURE <i>Irving Freeman</i>	DATE SIGNED 10/2/56																						
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 4, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery			22d. LOCATION (City, town, or county) Baltimore County, Maryland																		
23. FUNERAL DIRECTOR'S SIGNATURE Lessahn Funeral Home, 7401 Belair Rd., Balt., Md.				ADDRESS	24a. REC'D BY REGISTRAR T. J. Dawson	24b. REGISTRAR'S SIGNATURE L. Fairburn																	

CERTIFICATE OF DEATH

NAME

NAME

NAME

BUREAU Y.

OCT. 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09996

43

Reg. Dist. No.

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY		10022 Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fullerton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Silver Spring Road		d. STREET ADDRESS Silver Spring Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First Mrs. Millie	Middle Berry	Last Fink	4. DATE OF DEATH	Month October Year 30st 19 56
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/15/1896	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Thomas C. Spurrier		14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. John Adam Fink, Silver Spring Rd. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 174X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cereinoma- uterus (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Balto. 6, Md.	(County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 1A M, from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Richard R. Risler				ADDRESS (Street, city or town, state) 1 W. Overlea Ave., 10-31-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/3/56	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Road #14		ADDRESS	24a. REC'D BY REGISTRAR NOV - 1 1956	24b. REGISTRAR'S SIGNATURE Mrs. L. Ruck	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 the registrar prior to removal, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 1SM 9/55

CERTIFICATE OF DEATH

NO. 102-212

NO. 102-212

BUREAU V.

NOV 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09997

10023

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Anne Arundel Co.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr5mth2dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Maryland		d. STREET ADDRESS Box 461 - Route #2				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Orilla	Middle S. E.	Last Firor	4. DATE OF DEATH	Month October 16	Day 19	Year 56			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1881	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months 75	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME William Stansbury		14. MOTHER'S MAIDEN NAME Mary E. Bull								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No yes World War #1		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH								
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Generalized arteriosclerosis										
DUE TO (b) Generalized arteriosclerosis										
DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from May 14, 1954 , to Oct. 16, 1956 that I last saw the deceased alive on October 16, 1956 , and that death occurred at 10:05 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)							DATE SIGNED	
ACTUAL SIGNATURE	Stella Wachsler M.D.							SPRING GROVE STATE HOSPITAL 10-17-56		
PHYSICIAN'S NAME (Type)	Stella Wachsler, M. D.							Catchnsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/20/56	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Stm J. Sickerne & Sons - Baltimore, Md.	ADDRESS			24a. REC'D BY REGISTRAR J. E. Harry	24b. REGISTRAR'S SIGNATURE					
				DATE Oct. 18, 1956						

81-39007-172-AH 90 TWO MILE ROAD STATE GAME PARK

BUREAU V.

OCT 19 1956

RECEIVE ED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

V.S. A15ME(5)
5M 9/55 ✓

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09998

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salem</i>		c. LENGTH OF STAY IN 1b <i>23 yrs.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2815 Linwood Ave</i>		e. STREET ADDRESS <i>2815 Linwood Ave</i>	
f. NAME OF DECEASED (Type or print) <i>Leonard Fleischman</i>		4. DATE OF DEATH <i>Last October 8 1956</i>	5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>M</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>18 May 1887</i>		9. AGE (in years last birthday) <i>69 yrs.</i>	10. IF UNDER 1YEAR Months <i>0</i> Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>MACHINIST - CONT. CAN CO.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>GERMANY</i>	11. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Katherine ITTNER</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>215-03-3210</i>	17. INFORMANT <i>Mrs Rosa Fleischmann</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>Inst.</i>	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. DUE TO (b) DUE TO (c)		Myocardial Infarction	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Bronchial Asthma Chronic</i>		Other sclerosis Generalized Undit	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED <i>10-8-56</i>	
ACTUAL SIGNATURE <i>John C. Hyde</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>John C. Hyde</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/10/56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>PARKWOOD</i>		22d. LOCATION (City, town, or county) <i>BALTO Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5805 Hayford</i>		ADDRESS ADDRESS 24a. REC'D BY REGISTRAR <i>REC'D Oct. 10, 1956</i>	
		24b. REGISTRAR'S SIGNATURE <i>Dr. L. M. Bacon</i>	

BUREAU V. S.

OCT 11 1950

REGUL V. L.G.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09999

10025

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 8 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1620 Druid Hill Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First OTIS	Middle	Last FLEMING	4. DATE OF DEATH	Month October	Day 30	Year 1956
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1892	9. AGE (In years at birthday) 64	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Hours 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker		10b. KIND OF BUSINESS OR INDUSTRY Confectionery		11. BIRTHPLACE (State or foreign country) Lancaster Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Leonard R. Fleming		14. MOTHER'S MAIDEN NAME Sarah Griffin					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 218-03-0394		17. INFORMANT Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TUBERCULOSIS, PULMONARY, CHRONIC, FAR ADVANCED		DUE TO 002X		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) _____ DUE TO (c) _____							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. VA		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) 0 (State) 0	
21. I certify that I attended the deceased from October 22, 1956 , to October 30, 1956 , A.M. , and that death occurred at 10:40A.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 10/31/56	
ACTUAL SIGNATURE <i>Francis G. DICKEY</i>	PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, Chief, Medical Service, VAH, Fort Howard, Maryland		M.D. VAH, FORT HOWARD, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 2, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cem.		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State) 0
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles R. Law</i>	ADDRESS Charles R. Law Mortuary, 802-01, Madison Ave.		24a. REC'D BY REGISTRAR DATE 11/3/56		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farber</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 To GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. It should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10026

CERTIFICATE OF DEATH

10000
44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk, Maryland		c. LENGTH OF STAY IN lb 12 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		d. STREET ADDRESS 7524 Holabird Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7524 Holabird Ave.				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HOLDEN		First	Middle	Last	4. DATE OF DEATH 10	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH April 8, 1908	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months -	IF UNDER 24 HRS. Days -	Hours -	Min. -
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Foreman		10b. KIND OF BUSINESS OR INDUSTRY Steel Mfgr.		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Samuel C. Forsythe				14. MOTHER'S MAIDEN NAME Victoria Knox					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-6349		17. INFORMANT Robert D. Forsythe		Address same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X		<i>Condition of Lung</i>				INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 2 Kensington	
								(County) Baltimore (State) Maryland	
21. I certify that I attended the deceased from 10-19 , 19 56 to 10-21 , 19 56 , that I last saw the deceased alive on 10-21 , 19 56 , and that death occurred at 7457 M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state) Baltimore 22	
ACTUAL SIGNATURE <i>Jacqueline Collins</i>		M.D. 2 Kensington						DATE SIGNED 10-22-56	
PHYSICIAN'S NAME (Type) JACQUELINE COLLINS									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-56		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sally Ruth Bradley</i>		ADDRESS Dundalk, Maryland		24a. REC'D BY REGISTRAR PCT 241956		24b. REGISTRAR'S SIGNATURE <i>anson L. Farber</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Fill in and file.

This registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

OCT 24 1956

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may be retained by the hospital or attending physician.
 FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10027 CERTIFICATE OF DEATH

 10001 38
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)		Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Stoneleigh 30 yrs.		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6503 Maplewood Rd		6503 Maplewood Rd					
3. NAME OF DECEASED (Type or print)		First ROBERT	Middle E	Last FOUTZ	4. DATE OF DEATH Oct	Month 23	Day Year 1956
5. SEX male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 5, 1877	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Own Business		11. BIRTHPLACE (State of foreign country) Johnsville Frederick Co Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Solomon S Foutz		14. MOTHER'S MAIDEN NAME Mary Naille					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 217-18-0677		17. INFORMANT Mrs Mary L Crawford Westminster Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Decompressive Cardio Vascular Disease		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Arteriosclerosis (c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 23, 1956, to Oct 23, 1956, that I last saw the deceased alive on Oct 23, 1956, and that death occurred at 7:40 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE Lawrence C. Post M.D.						DATE SIGNED	
PHYSICIAN'S NAME (Type) LAURENCE C. Post							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 25 1956		22c. NAME OF CEMETERY OR CREMATORI Ebenezer		22d. LOCATION (City, town, or county) Glenfield	
						(State) Md	
23. FUNERAL DIRECTOR'S SIGNATURE Henry Winkins & Sons Co		ADDRESS 4905 York Rd		24d. REC'D BY REGISTRAR OCT 25 1956		24e. REGISTRAR'S SIGNATURE Mabel Gray	
				DATE			

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 29 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10028

CERTIFICATE OF DEATH

10002

Reg. Dist. No.

31

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page _____ may be referred to by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WOODLAWN		d. STREET ADDRESS 1749 LITTLE CREEK DR.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1749 LITTLE CREEK DR.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ALBERT B. FOX		First	Middle	Last	4. DATE OF DEATH 10 - 18 - 56	Month	Day	Year 19
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-5-1908		9. AGE (in years lost birthday) 48 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MEAT BUYER		10b. KIND OF BUSINESS OR INDUSTRY EDDIES SUP. MKT.		11. BIRTHPLACE (State or foreign country) PHILADELPHIA		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOSEPH FOX		14. MOTHER'S MAIDEN NAME IDA KLINE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 146-03-2490		17. INFORMANT MARY E. FOX		Address		
No								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO { (c)		<i>Generalized Circumscriptus Carcinoma of colon</i>				INTERVAL BETWEEN ONSET AND DEATH 18 mos		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from April 21 , 1953, to Oct 18 , 1956, that I last saw the deceased alive on Oct 18 , 1956, and that death occurred at 5 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 2310 Butan Ave. DATE SIGNED ACTUAL SIGNATURE Louis Blum, M.D. PHYSICIAN'S NAME (Type) Louis V. Blum								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 10/22/56		22b. DATE THEREOF 10/22/56		22c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		22d. LOCATION (City, town, or county) BALTO. MD (State)		
23. FUNERAL DIRECTOR'S SIGNATURE J. T. STANSBURY		ADDRESS 6411 Windsor Mill		24a. REC'D. BY REGISTRAR OCT 24 1956		24b. REGISTRAR'S SIGNATURE Dr. Wm. Martin		

CERTIFICATE OF DEATH

MURKIN

BUREAU V. S.

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10003

Reg. Dist. No.

44

10029

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
BALTIMORE MARYLAND		a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sparrows Point</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>SPARROWS POINT HOSPITAL</i>		d. STREET ADDRESS <i>401 EDSDALE ROAD</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Gillespie Jesse</i>		First BOYD Middle <i>Gillespie</i>	
4. DATE OF DEATH Month Day Year <i>APR. 13, 1906</i>		Lost Month Day Year <i>16 27 1956</i>	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>APR. 13, 1906</i>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years, months, days) <i>45 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Mechanical Maintenance</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Steel Mfg.</i>	
11. BIRTHPLACE (State or foreign country) <i>Henry Co., Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas I. Gillespie</i>		14. MOTHER'S MAIDEN NAME <i>Belle Davis</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NONE</i>		16. SOCIAL SECURITY NO. <i>242-05-4663</i>	
17. INFORMANT <i>Mrs. Edith R. Gillespie-401 Edsdale Rd., Balt.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coventry Conclusion</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____			
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Jack C. Collins</i>		DATE SIGNED <i>10-27-56</i>	
EXAMINER'S NAME (Type) <i>JACK C. COLLINS</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>OCT. 30, 1956</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>SHERWOOD CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>ROANOKE, VIRGINIA</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>WM. J. TICKNER AND SONS, BALTIMORE, MD.</i>		ADDRESS 24a. REC'D BY REGISTRAR <i>DATE 29 1956</i>	
VS. A15ME(5) 5M 9/55		24b. REGISTRAR'S SIGNATURE <i>Lawson L. Farber</i>	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION 38

BUREAU V. 2

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10004 45

10030

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Marsh			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ivy Hill Nursing Home		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Elizabeth First Ann Gladfelter		4. DATE OF DEATH Oct Month 10 Day Year 1 56 19					
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 23, 1868	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Talbott		14. MOTHER'S MAIDEN NAME Susan Daily		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Family records		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT 8, 1956 to OCT 10, 1956 that I last saw the deceased alive on OCT 9, 1956 , and that death occurred at 5:30A M , from the causes and on the date stated above. ACTUAL SIGNATURE JM Baumgardner M.D. Baltimore Md ADDRESS (Street, city or town, state) Shrewsbury, Penna. DATE SIGNED 10/10/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 13, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Luthern Cemetery,		22d. LOCATION (City, town, or county) Shrewsbury, Penna. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE JM Burns Sons,		ADDRESS Towson, Maryland		24a. REC'D BY REGISTRAR DATE Oct 15 1956		24b. REGISTRAR'S SIGNATURE Edith Shuler	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be reigned by the hospital or attending physician.
 MEDICAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BE JOURNAL OF INTELLIGENT SYSTEMS

BUREAU Y.

OCT 15 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10005

10031

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md b. COUNTY Baltor	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 40 yr	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 611 Harlem Ave		e. STREET ADDRESS same	
3. NAME OF DECEASED (Type or print) Gertrude M. Glanville		4. DATE OF DEATH Oct. 20	Month Year 1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/28/1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME John DeGraft		14. MOTHER'S MAIDEN NAME Parker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Gertrude Nipson Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE UTERUS 3 DUE TO 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO (OPERATION AND METASTESES) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 0 2 YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 0	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 0 p. m. 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from AUG, 18, 1953, to OCT, 20, 1956, that I last saw the deceased alive on OCT, 19, 1956, and that death occurred at 4:30PM, from the causes and on the date stated above. ACTUAL SIGNATURE S. Lloyd Johnson M.D. ADDRESS (Street, city or town, state) 6348 FREDERICK ROAD DATE SIGNED			
PHYSICIAN'S NAME (Type) S. LLOYD JOHNSON, M.D. 6348 FREDERICK ROAD, CATONSVILLE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/23/56	22c. NAME OF CEMETERY OR CREMATOR Y Lorrame	22d. LOCATION (City, town, or county) (State) Baltor Co
23. FUNERAL DIRECTOR'S SIGNATURE M. Lloyd & Son	ADDRESS 28	24a. REC'D BY REGISTRAR DATE 10/24/56	24b. REGISTRAR'S SIGNATURE T. E. Harry

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

81-380048-MTJABR 30 JULY 1980 STATE OF WASHINGTON

1956 5

THE ELEVENTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10032 CERTIFICATE OF DEATH

10006
Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY
 OR and give nearest town) (in this place)
 TOWN Rural: Towson

HOSPITAL OR Eudowood Sanatorium
 INSTITUTION OR STREET ADDRESS Towson 4, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore
 CITY (If outside corporate limits, write RURAL and give nearest town)
 OR TOWN Lutherville
 STREET ADDRESS 504 Spring Avenue

3. NAME OF
DECEASED:
(Type or Print)

MALE

(First) HARTWELL

WHITE

(Middle) D.

SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify): MARRIED

(Last) GLASS

12-25-26

4. DATE
OF
DEATH:

29

(Month) October

25

(Day) 1956

IF UNDER 1 YEAR

Months Days Hours Min.

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED.

(Specify): MARRIED

8. DATE OF BIRTH:

12-25-26

9. AGE last birthday:

29

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION Give kind of
work done during most of working life,
even if retired):

ENGINEER MECHANICAL Engineer Virginia

10b. KIND OF BUSINESS OR
INDUSTRY:11. BIRTHPLACE (State or foreign country): 12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME:

JAMES B. GLASS

14. MOTHER'S MAIDEN NAME:

ANNA RICHARDS

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

Yes

World War II

16. SOCIAL SECURITY NO.: 17. INFORMANT & ADDRESS: Personal History
231-24-6461 Hospital Records, Eudowood Sanatorium

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

163X
Immediate cause(a) Adeno carcinoma left lung
DUE TOInterval Between
Onset And Death

18 mos.

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.(b) _____
DUE TO

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

7/26/56

Lymph nodes swollen

20. AUTOPSY?

Yes No 21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF
INJURYINJURY OCCURRED
While at
Work Not While
At Work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-26-1956 to 10/25-1956, that I last saw the deceased

alive on 10/25-1956, and that death occurred at 5:50 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

Oct. 26, 1956

NAME OF CEMETERY OR CREMATORIUM

John M. Oakey, Funeral Home

LOCATION (City, town, or county)

Roanoke, Virginia

(State)

REMOVAL
DATE REC'D BY LOCAL
REGISTAR

REGISTRAR'S SIGNATURE

Mabel C. Gray

FUNERAL DIRECTOR

John Barnes' Son

ADDRESS

Towson, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE NEARLY, WITH UNFADING INK. Supply every item of information carefully. The correct
age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10007

10033 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH. COUNTY <u>Baltimore County</u>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural - Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7400 Belmont Avenue</u>		STREET ADDRESS <u>7400 Belmont Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>A.</u>	(Last) <u>Goldys</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/12/1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>still operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>J. S. Young Co.</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>	9. AGE last birthday 84
13. FATHER'S NAME <u>John Andrew Goldys</u>	14. MOTHER'S MAIDEN NAME <u>Sophia</u>	12. CITIZEN OF WHAT COUNTRY <u>Poland</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>212-10-0983</u>	17. INFORMANT <u>Mary Goldys 7400 Belmont Ave</u>	
18. MEDICAL CERTIFICATION			

MARGIN RESERVED FOR BINDING

PLEASE WRITE MAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age
is especially important. Physicians: please write the causes of death clearly and legibly.

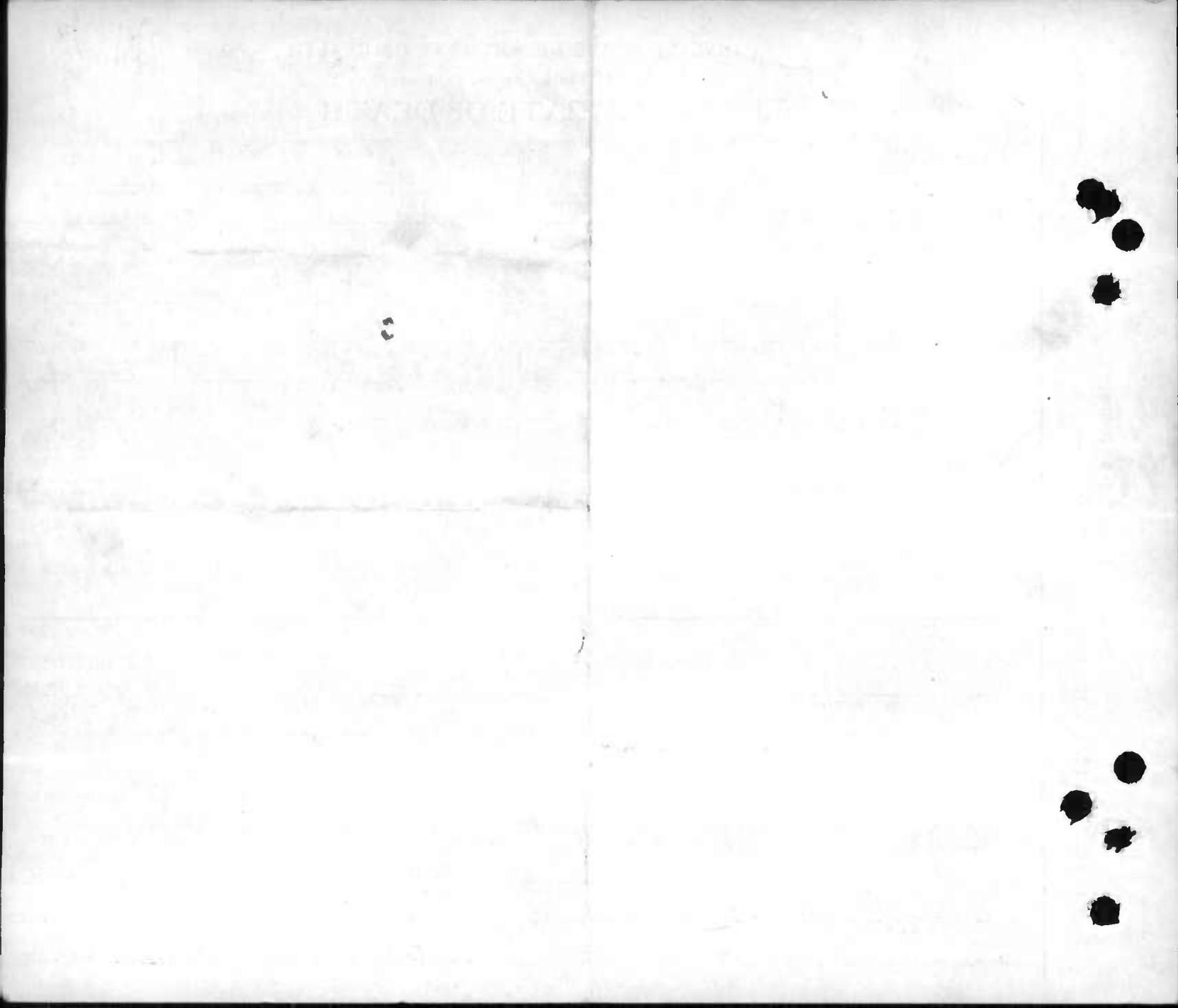
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(a) <u>Cerebral Vascular Accidents</u>	<u>7 days</u>
	(b) <u>Arteriosclerotic cardiovascular disease</u>	<u>> 10 yrs.</u>
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., 19....., from the causes and on the date stated above. SIGNATURE <u>David A. Levy M.D.</u>			
(Degree or title) ADDRESS <u>434 Eastern Ave. Essex Md 10/1/56</u>			
DATE SIGNED			

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>10/24/56</u>	NAME OF CEMETERY OR CREMATORIAL <u>Sacred Heart of Jesus</u>	LOCATION (City, town, or county) (State) <u>Baltimore Co. Md.</u>
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>✓</u>	24. FUNERAL DIRECTOR <u>Wm. Fialkowski</u>	ADDRESS <u>2007 Eastern Ave</u>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10008

Reg. Dist. No.

33

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		10034 Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b Visiting		a. STATE Maryland	b. COUNTY Baltimore
Owings Mills				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Lyons Mill Road South Road		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First CLINTON	Middle LYNCH	LAST GOODWIN	4. DATE OF DEATH OCT. 15, 1956
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH August 25, 1888	9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Veterinarian		10b. KIND OF BUSINESS OR INDUSTRY Veterinary		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME Franklin P. Goodwin		14. MOTHER'S MAIDEN NAME Unknown Josephine Bosley		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes ✓ W.W. #1		16. SOCIAL SECURITY NO. 220-34-7320		17. INFORMANT Francis Goodwin (Wife) Pikesville, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address INTERVAL BETWEEN ONSET AND DEATH 20 min.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> none		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20f. (City or town) none		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)	D. D. Caples D. D. Caples, M. D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	DATE SIGNED 10-17-56
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) Pikesville, Md.	
Burial	10-18-56	Druid Ridge		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Frank H. Neurall - Pikesville 8. Sub.				DATE OCT 19 1956	Mary Elsie

WEDNESDAY SEVEN DASHWOOD IS RECALLED BY
MEDICAL EXAMINER CERTIFICATE OF DEATH

BUREAU V. S.

OCT 19 1956

REGEVIEW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10035

CERTIFICATE OF DEATH

Reg. Dist. No. 10009 38

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Parkville</i>		c. LENGTH OF STAY IN lb <i>b. COUNTY Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2904 Hillcrest Avenue</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Agnes Estella Gourley</i>		First <i>Middle</i>	Last <i>Month Day Year</i>
S. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 19, 1883</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>
13. FATHER'S NAME <i>George Nicholson</i>		14. MOTHER'S MAIDEN NAME <i>Mary Timmins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Mary Kram, 2904 Hillcrest Avenue #14</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>157X</i>		Address <i>INTERVAL BETWEEN ONSET AND DEATH</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b) Pancreatic Carcinoma</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Malnutrition and Paralytic illness</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>20f. (City or town) (County) (State)</i>	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>10-2</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10-1</u> , 19 <u>56</u> , and that death occurred at <u>306</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John C. Hyde</i>	ADDRESS (Street, city or town, state) <i>M.D. 1527 Belair Rd</i>		
PHYSICIAN'S NAME (Type) <i>JOHN C. HYDE</i>	DATE SIGNED <i>10-2-56</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/5/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Cem.</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>	ADDRESS <i>Leonard J. Ruck 5305 Harford Road #14</i>	24a. REC'D BY REGISTRAR DATE <i>Oct 5 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Dr. M. Burns</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to removal. Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU
REGISTRY
OCT 5 1956

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 1810010
45**CERTIFICATE OF DEATH**

10036

Reg. Dist. No.....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		MARYLAND LENGTH OF STAY (in this place) 8 YEARS		STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		COUNTY BALTO ROSEDALE (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1538 ROSEWICK AVE				STREET ADDRESS 1538 ROSEWICK AVE			
3. NAME OF DECEASED (Type or Print)		(First) MARY (Middle) E (Last) GRANVILLE		4. DATE OF DEATH 10/30/56		(Month) (Day) (Year)	
S. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH NOV 13, 1876	9. AGE last birthday 79 yrs.	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTO. MD		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME LAWRENCE KNOBEL		14. MOTHER'S MAIDEN NAME CATHERINE LETCHEL					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS ELIZABETH SCHMAELZLE 1538 ROSEWICK AVE		INTERVAL BETWEEN ONSET AND DEATH 30 minutes	
IMMEDIATE CAUSE 420.0		ANTECEDENT CAUSE(S) DUE TO Coronary Occlusion		18. MEDICAL CERTIFICATION Arteriosclerotic Heart Disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) DUE TO (C)		10 years			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) 8:55a		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. INJURY OCCURRED Jan. 19, 54		21f. HOW DID INJURY OCCUR? to Oct. 30, 1956			
22. I hereby certify that I attended the deceased from Jan. 19, 54 , to Oct. 30, 1956 , that I last saw the deceased alive on Oct. 30, 1956 , and that death occurred at 8:55a M, from the causes and on the date stated above. SIGNATURE <i>Jane R. May, M.D.</i> ADDRESS (Street, city, town, state) 8019 Philadelphia Rd. Baltimore 6, Md. DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11/2/56		NAME OF CEMETERY OR CREMATORIUM ZION EVAN. CEMT		LOCATION (City, town, or county) (State) STEMMERS. RUN. MD	
24. REC'D BY REGISTRAR NOV 5 1956		REGISTRAR'S SIGNATURE <i>Ethel Shirley</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Laurene Hoffmann 3218 Hudson St</i>			
DATE				ADDRESS			

OF DOMESTIC-STATE-TELETYPE STATE CHANNEL

UNITED STATES OF AMERICA

BUREAU V. S.

NOV 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10011

Reg. Dist. No.

10037

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard			c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater, Maryland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital			d. STREET ADDRESS Rt. #1 Box 442 A		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First JAMES	Middle A.	Last GREEN	4. DATE OF DEATH October 11 1956	Month Day Year
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4, 1887	9. AGE (In years (In birthday) 69 yrs.)	10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer unemployed			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME John Green			14. MOTHER'S MAIDEN NAME Harriett Jilling		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I			16. SOCIAL SECURITY NO. 43-22-0618		
17. INFORMANT Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Maryland			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		
491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO					
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE- Duration Unknown			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VA	20f. (City or town) VA	(County) (State)
21. I certify that I attended the deceased from October 5, 1956 , to October 11, 1956 , and that death occurred at 12:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Francis G. Dickey M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/11/56					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) FRANCIS G. DICKEY, Chief Medical Service					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56	22c. NAME OF CEMETERY OR CREMATORIY Annapolis National	22d. LOCATION (City, town, or county) Annapolis, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, 108 Washington St., Annapolis, Md.			ADDRESS	24a. REC'D BY REGISTRAR DATE 15 1956	24b. REGISTRAR'S SIGNATURE Frank L. Farley

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Fill in by the funeral director, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

31 ЗКОЛІСТІВ-ІНДІЯНОВІ ПІДПІДЧАСОВІ СТАРІ ОНАДУДАМ

BUREAU V.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10038

CERTIFICATE OF DEATH

10012
40

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE M.D.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KINGSVILLE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KINGSVILLE				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CHAPMAN ROAD				d. STREET ADDRESS CHAPMAN RD.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First HARRY	Middle C	Lost GRIFFIN	4. DATE OF DEATH OCT. 19 1956	Month OCT.	Day 19	Year 1956
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH NOV. 13-1893	9. AGE (in years last birthday) 63 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BARBER				10b. KIND OF BUSINESS OR INDUSTRY OWN	11. BIRTHPLACE (State or foreign country) BALTO. MD.	12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME HARRY GRIFFIN				14. MOTHER'S MAIDEN NAME ALMIRE OREBEN				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 215-32-0143	17. INFORMANT ANNA GRIFFIN	Address ABOVE		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1				INTERVAL BETWEEN ONSET AND DEATH 6 hrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Cardiovascular disease				DUE TO Arteriosclerotic Cardiovascular disease				
DUE TO Diabetes				INTERVAL BETWEEN ONSET AND DEATH 20 yrs.				
DUE TO Diabetes								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Oct. 19, 1956, to Oct. 19, 1956, that I last saw the deceased alive on Oct. 19, 1956, and that death occurred at 2:50 P.M., from the causes and on the date stated above.				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) BALTO.	(County) (State) M.D.	
21. I certify that I attended the deceased from Oct. 19, 1956 , to Oct. 19, 1956 , that I last saw the deceased alive on Oct. 19, 1956 , and that death occurred at 2:50 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE William A. Tyson PHYSICIAN'S NAME (Type) William A. Tyson				ADDRESS (Street, city or town, state) Kingsville, Md. 10-20-56				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 22-56	22c. NAME OF CEMETERY OR CREMATORIAL MORELAND PARK	22d. LOCATION (City, town, or county) BALTO. MD.				
23. FUNERAL DIRECTOR'S SIGNATURE John J. Flannery				24a. REC'D BY REGISTRAR DATE OCT 24 1956	24b. REGISTRAR'S SIGNATURE Dr. Walter Hammett			
ADDRESS 418 Eastern Ave., Case 21-Md.								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it may be detached for use as the burial-transit permit. Then please remove carbon paper, ~~as 1 copy~~ and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TEXAS STATE DEPARTMENT OF HEALTH - SAN ANTONIO

FORM 52 - CERTIFICATE OF DEATH

RECEIVED

DEPT. OF PUBLIC SAFETY

STATE OF TEXAS

REGISTRATION NO.

EXPIRATION DATE

ISSUE DATE

BUREAU V. S.

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		10039		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore		MARYLAND		a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY	Howard
Catonsville		19yrs2mt26dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				Woodbine, Maryland	
SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	John		Grimes		October	24,	19 56

5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
male	white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	unknown	71 ⁷ yrs.	Months	Days

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer	farming	Mayland	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unknown	unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
unknown	---	unknown	Records: SPRING GROVE STATE HOSPITAL

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		
DUE TO	(b)	<i>Coronary Thrombosis</i>
	DUE TO	<i>Hypertension</i> <i>Cerebral vascular disease</i>
	(c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<i>Deabetes Mell.</i>		

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		ERROR
	<i>Fallen from bed</i>		

20c. TIME OF INJURY Month, Day, Year Hour a.m.	20d. INJURY OCCURRED While at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
6/26/56 20x 19 56	Not while at work	bedroom	<i>Florence, Md.</i>

21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE	<i>George M. Kieffer</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED
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EXAMINER'S NAME (Type)	George M. Kieffer, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>

10-24-56

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	10-25-56	Jennings Chapel	<i>Florence, Md.</i>

23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 29 1056	24b. REGISTRAR'S SIGNATURE <i>E. Harry</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 3 may be retained by your firm.
FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar for removal.

BUREAU V.

OCT 29 1956

REFUGEE EO

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10014
CERTIFICATE OF DEATH

Reg. Dist. No. 33 44

1. PLACE OF DEATH a. COUNTY Baltimore		10040 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 4 Days		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
3. NAME OF DECEASED (Type or print) PAUL		First T.	Middle GROVE	Last October	4. DATE OF DEATH Month 20 Day 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 10/20/93	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Creamery Company		11. BIRTHPLACE (State or foreign country) Altantic, Iowa	
13. FATHER'S NAME John E. Grove		14. MOTHER'S MAIDEN NAME Dora Hedges		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW-I Unknown		17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL FAILURE DUE TO ARTERIOSCLEROTIC HEART DISEASE AURICULAR AND VENTRICULAR FIBRILLATION				INTERVAL BETWEEN ONSET AND DEATH SUDDEN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0		(b)		(c) UNDETERMINED	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (g) UNDIFFERENTIATED BRONCHIOGENIC CARCINOMA, RIGHT UPPER LOBE BRONCHUS WITH METASTASIS TO VERTEBRAE				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, Fort Howard, Maryland	
20f. (City or town) VAH, Fort Howard, Maryland		(County)		(State)	
21. I certify that I attended the deceased from October 15, 1956 , to October 19, 1956 , and that death occurred at VAH, Fort Howard, Maryland , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 10/20/56	
ACTUAL SIGNATURE Rolando P. Ponce de Leon		M.D.			
PHYSICIAN'S NAME (Type) ROLANDO P. PONCE DE LEON		VAH, Fort Howard, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/23/56		22c. NAME OF CEMETERY OR CREMATORIAL Westminster Cemetery	
22d. LOCATION (City, town, or county) Westminster, Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Harvey Bankart & Sons Funeral Home		ADDRESS Main Street Westminster, Maryland		24a. REC'D BY REGISTRAR DATE 10/20/56	
				24b. REGISTRAR'S SIGNATURE Henry B. Shaefer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. See 1 and 2 and be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF GOVERNMENT - BALTIMORE

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10015

Item 2 FilmG20611-14-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY Baltimore		10041 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b C. LENGTH OF STAY IN 1b		b. COUNTY Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home-Harlem Lane				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gatonsville Baltimore City (12)	
3. NAME OF DECEASED (Type or print) JENNIE		First	Middle	Last	4. DATE OF DEATH Oct. 27, 1956
5. SEX female		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 23, 1906	9. AGE (In years last birthday) 50 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.	
13. FATHER'S NAME William Sauble		14. MOTHER'S MAIDEN NAME Jennie Little			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) None		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Viola Kendall - 2300 E. Fayette St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175X		INTERVAL BETWEEN ONSET AND DEATH Cardiac failure 2 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO General debility secondary		INTERVAL BETWEEN ONSET AND DEATH 5 month			
(c) DUE TO In Cancer fell away		INTERVAL BETWEEN ONSET AND DEATH 9 months			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) 4605 Edmondson Ave	(State) Baltimore
21. I certify that I attended the deceased from June , 1952, to Oct 27 , 1952, that I last saw the deceased alive on Oct 26 , 1952, and that death occurred at 7 1/2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 4605 Edmondson Ave					
ACTUAL SIGNATURE Cliff Ratliff, Jr.		DATE SIGNED 10/27/52			
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, JR.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/56	22c. NAME OF CEMETERY OR CREMATORIUM Meadow Branch Cem.	22d. LOCATION (City, town, or county) Westminster, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickener & Sons - Baileys, Md.		ADDRESS 10/31/56	24a. REC'D BY REGISTRAR Nov. 1, 1956	24b. REGISTRAR'S SIGNATURE W. E. Harry	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relocked by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

81. BROWNSTEIN-WEINER TO THE STATE OF CALIFORNIA

BUREAU V. S.

NOV 2 1956

REGELVÆRDE

Item 9 Film 206 11-2-56 et

CERTIFICATE OF DEATH

10042

Reg. Dist. No. 41

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place) Sparrows Point 26 years	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY Baltimore Sparrows Point Md. Box 311 Penwood Ave.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	ADDRESS Box 311 Penwood Ave.	STREET ADDRESS	(If rural give location) Box 311 Penwood Ave.
3. NAME OF DECEASED (First) George Ellwood Hammond (Middle) (Last)		4. DATE OF DEATH Oct 24 1956	
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Nov. 26-1889
9. AGE last birthday 67 yrs.	10. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.	11. BIRTHPLACE (State or foreign country) Middleburg - Penna.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roll-setter	10b. SOCIAL SECURITY NO. 213-07-8479	14. MOTHER'S MAIDEN NAME Anna M. Cain	13. FATHER'S NAME Elmer Ellsworth Hammond
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No	16. ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)	17. INFORMANT & ADDRESS Bertha B. Hammond Box 311 Penwood Ave	I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Heart Failure INTERVAL BETWEEN ONSET AND DEATH 5 days.
18. MEDICAL CERTIFICATION	Arrivo-sclerotic heart Disease 10 years.		
19e. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 1</u> , 1956, to <u>Oct 24</u> , 1956, that I last saw the deceased alive on <u>Oct 23</u> , 1956, and that death occurred at <u>Bethel</u> , from the causes and on the date stated above.			
SIGNATURE <u>R. L. Dawson</u>	M. D.	ADDRESS (Street, city, town, state) <u>520 1st St. S.E. Apt. 7, Baltimore, Md.</u>	DATE SIGNED <u>Oct 24, 1956</u>
23. BURIAL, CREMATION, REMOVAL* (SPECIFY) <u>Burial</u>	DATE THEREOF <u>10/27/56</u>	NAME OF CEMETERY OR CREMATORIAL <u>Glen Haven</u>	LOCATION (City, town, or county) <u>Baltimore</u> (State) <u>Md.</u>
24. REC'D BY REGISTRAR <u>CT 29 1956</u>	REGISTRAR'S SIGNATURE <u>Dawson L. Larkey</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Sassalm Funeral Home 7401 Belair Rd</u>	ADDRESS <u>6</u>

BY THE TRADERS STATE CHARTER

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
OCT 29 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10043

CERTIFICATE OF DEATH

10017

Reg. Dist. No. 38

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	c. LENGTH OF STAY IN 1b 7 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent		d. STREET ADDRESS 1001 West Joppa Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Sister Mary Beda (Hanly)	Middle	Last
4. DATE OF DEATH	Month Oct. 5, 1956	Day	Year 19
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1874
9. AGE (In years lost birthday) 81	10. IF UNDER 1 YEAR Months 81	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun	10b. KIND OF BUSINESS OR INDUSTRY Convent	11. BIRTHPLACE (State or foreign country) Brooklyn, New York	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Timothy Hanly		14. MOTHER'S MAIDEN NAME Mary Ward	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none	17. INFORMANT Convent Records, 1001 West Joppa Rd. Towson
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH Sudden	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Generalized Arteriosclerosis 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 8, 1956 to Oct. 8, 1956 , that I last saw the deceased alive on October 4, 1956 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. O'Donnell		ADDRESS (Street, city or town, state) 7501 York Road	
PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		DATE SIGNED 10/6/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Convent Cemetery
22d. LOCATION (City, town, or county) 1001 W. Joppa Rd. Towson, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE B. Vernon Lemmon		ADDRESS 4611 Park Heights Ave.	24a. REC'D BY REGISTRAR DATE Oct. 8 1956
		24b. REGISTRAR'S SIGNATURE Mabel Grays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10044

CERTIFICATE OF DEATH

10018 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 236 Hilton Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	(Also: ROBERT ^{1st} ROBERT)	H. Middle (NMI)	HANNA) Last HANNA	4. DATE OF DEATH	Month October	Day 30	Year 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1898	9. AGE (In years from last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		10b. KIND OF BUSINESS OR INDUSTRY Insurance Co.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Robert Hanna				14. MOTHER'S MAIDEN NAME Susan Muir			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DIABETES MELLITUS 260X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) NEPHROSCLEROSIS				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
DUE TO cause (c)						UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VA	(County)	(State)	
21. I certify that attended the deceased from October 24, 1956 to October 30, 1956 and last saw the deceased at 3:45 P. M. , and that death occurred at 3:45 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED			
ACTUAL SIGNATURE	<i>Constantine J. Papastrat</i>		VAH, FORT HOWARD, MARYLAND	10/31/56			
PHYSICIAN'S NAME (Type)	CONSTANTINE J. PAPASTRAT, M.D.		VAH, FORT HOWARD, MARYLAND				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-2-56	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edgar Lane</i>	ADDRESS Edgar Lane Funeral Home, Church Hill, Md.		24a. REC'D BY REGISTRAR 10V5 1956	24b. REGISTRAR'S SIGNATURE <i>Lawson L. Farley</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU Y. S.

NOV 5 1956

REGELV FEU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10019

Reg. Dist. No. 33

CERTIFICATE OF DEATH

10045

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hesterstown</i>		c. LENGTH OF STAY IN 1b <i>13 years</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <i>Cerry Hill Lord</i>	
3. NAME OF DECEASED (Type or print)	First <i>MARY</i>	Middle <i>BELLE</i>	4. DATE OF DEATH Month <i>October</i> Day <i>30</i> Year <i>1956</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>May 22 1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i></i>	
13. FATHER'S NAME <i>Calvin Pensyl</i>		14. MOTHER'S MAIDEN NAME <i>Clara Belle Heller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>156-1</i>	
17. INFORMANT <i>Mr. Emory Heiges, Hesterstown Md.</i>		Address <i>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma - liver</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 years</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <i></i> (c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>August</i> , 19 <i>53</i> to <i>October 30, 1956</i> that I last saw the deceased alive on <i>October 29, 1956</i> , and that death occurred at <i>6:45 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clarence E. McWilliams</i>	ADDRESS (Street, city or town, state) <i>Hesterstown, Maryland Oct 30, 1956</i>		
PHYSICIAN'S NAME (Type) <i>J. F. Eline & Sons</i>	DATE SIGNED <i>Oct 30, 1956</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Nov. 3, 1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>B. 92 & 1220</i>	22d. LOCATION (City, town, or county) <i>B. 92 & 1220, Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Eline & Sons Hesterstown Md</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE 10 30-56	24b. REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10046

CERTIFICATE OF DEATH

10020 33
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i>		c. LENGTH OF STAY IN 1b 2 years 7 mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Tug School</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Rodney Earl</i>		First <i>Rodney</i>	Middle <i>Earl</i>
4. DATE OF DEATH <i>October 29 1956</i>		Last <i>Hellmig</i>	Month <i>October</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/15/52</i>
9. AGE (In years lost birthday) <i>3 yrs.</i>	10. IF UNDER 1 YEAR <i>3 months</i>	11. IF UNDER 24 HRS. <i>Days Hours Min.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Miner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
10c. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Earl Francis Hellmig</i>		14. MOTHER'S MAIDEN NAME <i>Marilyn Elizabeth Miller</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Meredith S. Hale</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4700 355 X</i> DUE TO as central respiratory failure	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i>organic brain lesions</i> (c) DUE TO <i>Kernictonus</i>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Parkwood</i>
20f. (City or town) <i>Baltimore</i>		(County) <i>Md.</i>	
(State) <i>MD.</i>			
21. I certify that I attended the deceased from <i>3/15/1954</i> , to <i>10/29/1956</i> , that I last saw the deceased alive on <i>10/29/1956</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Richard Lindenberg, Pathologist</i>		ADDRESS (Street, city or town, state) <i>10/30/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-31-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood</i>
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles G. Cremation 8802 Harford Rd.</i>		24a. REC'D BY REGISTRAR <i>NOV 2 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Mary Elsie</i>
		DATE	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

BUREAU V.

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9981

CERTIFICATE OF DEATH

10021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 4603 Lincoln Drive		d. STREET ADDRESS 4603 Lincoln Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle Daniel	Last Henry
4. DATE OF DEATH	Month October	Day 22	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 8, 1885
9. AGE (In years lost birthday) yrs. 75	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Supt.		10b. KIND OF BUSINESS OR INDUSTRY Fidelity Deposit Co. Baltimore, Md.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George W. Henry		14. MOTHER'S MAIDEN NAME Margaret Elizabeth Gows	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO. 216-10-4283 17. INFORMANT Donald D. Henry	
		Address 1239 Ten Oaks Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Embolism -			
612X DUE TO Coronary Embolism -			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterial or Phlebitis - in any form			
DUE TO Arterial or Phlebitis - in any form			
C (c) Postembolism			
INTERVAL BETWEEN ONSET AND DEATH Moderate			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ✓19 p. m.		20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on Oct 4/56, 1956, and that death occurred at 6 R. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Frederick J. Beiter		ADDRESS (Street, city or town, state) M.D. 1014 Frances Ave - Baltimore 27-MD DATE SIGNED	
PHYSICIAN'S NAME (Type) FREDERIC V. BEITER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/25/56	22c. NAME OF CEMETERY OR CREMATORIALoudon Park Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard		ADDRESS 4107 Wilkins Avenue	24a. REC'D BY REGISTRAR DCT 25 1956
			24b. REGISTRAR'S SIGNATURE Dr. George M. Kieffer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in blank, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

MISSOURI STATE DEPARTMENT OF HEALTH - CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

DEATH

DEATH

DEATH

BUREAU Y.

OCT 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10047 CERTIFICATE OF DEATH

10022

Reg. Dist. No. 31

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ROCKDALE		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - ROCKDALE		d. STREET ADDRESS 8343 LIBERTY Rd			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8343 LIBERTY Rd				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First ALICE	Middle ESTELLE	Last HERSHBERGER	4. DATE OF DEATH 10	Month 10	Day 2	Year 1956	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 29, 1875	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME SANDERS		14. MOTHER'S MAIDEN NAME NOT KNOWN							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. NONE		17. INFORMANT SON - WAYNE HERSHBERGER.		Address 8343 LIBERTY Rd BALTO. 7, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA		DUE TO 446X		INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. hypertension -		(b) DUE TO GENERALIZED ARTERIOSCLEROSIS				15 YEARS.			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8204 LIBERTY Rd, BALTO. 7, Md.		20f. (City or town) BALTO. 7, Md.		(County) MD	(State) Md.
21. I certify that I attended the deceased from OCTOBER 1, 1956 to OCTOBER 2, 1956 , that I last saw the deceased alive on OCTOBER 1, 1956 , and that death occurred at 4:53 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 8204 LIBERTY Rd, BALTO. 7, Md.		DATE SIGNED 10/1/56	
ACTUAL SIGNATURE Edwin L. Pierpont,		M.D.							
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/56		22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cem.		22d. LOCATION (City, town, or county) BALTO. 7, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. J. Vickner & Sons - Balt. 17, Md.		ADDRESS J. J. Vickner & Sons - Balt. 17, Md.		24a. REC'D BY REGISTRAR 10/8/1956		24b. REGISTRAR'S SIGNATURE J. J. Vickner & Sons - Balt. 17, Md.			

CERTIFICATE OF DEATH

BUREAU V. I.

T. A. 1956

RECEIVED

1

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral director. Page 6 should be given to the registrar for burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
10023 44 Reg. Dist. No.									
1. PLACE OF DEATH a. COUNTY		10048 BALTIMORE Co. MARYLAND							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b SPARROWS POINT							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHLEHEM STEEL CO., INC. BALTIMORE 3Y01-4							
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle RICHARD	Last HEYMAN	4. DATE OF DEATH 10 JAN. 1956	Month 10	Day 27	Year 1956	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 19, 1898	9. AGE (in years last birthday) 58 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?
BRICK LAYER			BETH. STEEL CO.			BALTIMORE, MD.			
13. FATHER'S NAME GEORGE R. HEYMAN.			14. MOTHER'S MAIDEN NAME MARY A. LEHR.						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES WORLD WAR I			16. SOCIAL SECURITY NO.			17. INFORMANT MAGDALEN HEYMAN SAME.			Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 912.3 DUE TO Fracture Dislocation Lumbar Spine									
Condition, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DUE TO Fracture left Tibia & Fibula									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Cause of Death. Hit by fork lift truck while in box car at work									
20c. TIME OF INJURY Hour p. m.		Month, Day, Year 10/27/56	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) shipyard	20f. (City or town) Bethlehem Steel Co. Balto. Md.	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>William Vojatz</i>		DATE SIGNED 10-28-56							
EXAMINER'S NAME (Type) Charles L. Guler		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-31-56		22c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART CEM.		22d. LOCATION (City, town, or county) GERMAN HILL RD., MD.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. Guler		ADDRESS 901 S. CONKLING ST. BALTO., MD.		24a. REC'D BY REGISTRAR Oct. 30, 1956		24b. REGISTRAR'S SIGNATURE <i>Levi L. Hartley</i>			

EXAMINER'S CERTIFICATE OF DEATH

STATE OF NEW YORK - ACCORDING TO

BUREAU X.

OCT 31 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film 0206 11-2-56 et

10024

Reg. Dist. No.

30

10049

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN 1b

12 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

SPRING GROVE STATE HOSPITAL

3. NAME OF
DECEASED
(Type or print)First
Regina

Middle

Last
Hirshman

4. SEX

female

6. COLOR OR RACE

white

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

1902

9. AGE (In years
lost birthday)
54 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

housewife

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Isaac Lewkowicz

14. MOTHER'S MAIDEN NAME

Fajgla Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

unknown

17. INFORMANT

Records: SPRING GROVE STATE HOSPITAL

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary thrombosis

INTERVAL BETWEEN
ONSET AND DEATH

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

Arteriosclerotic cardiovascular disease

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING
OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m.20d. INJURY OCCURRED
White Not while
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from October 14, 1956, to October 25, 1956, that I last saw the deceased alive on Oct. 25, 1956, and that death occurred at 11:55 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Suzanne Wachsler

M.D.

SPRING GROVE STATE HOSPITAL 10-25-56

PHYSICIAN'S
NAME (Type)

Stella Wachsler, M. D.

Catonsville 28, Maryland

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

10-26-1956

22c. NAME OF CEMETERY OR CREMATORIUM

POSEDALE

22d. LOCATION (City, town, or county)

Baltimore

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

Jack Lewis Inc - 2100 Eaton Place

ADDRESS

24a. REC'D BY REGISTRAR

DATE OCT 29 1956

24b. REGISTRAR'S SIGNATURE

J. E. Harrys

81 ЭКОНОМИКА И УЧЕБА В УНИВЕРСИТЕТЕ СОВРЕМЕННОГО МИРА

BUREAU U. S.

OCT 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10050

CERTIFICATE OF DEATH

10025

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ESSEX		c. LENGTH OF STAY IN lb LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 204 MACE AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM HORMANN	First	Middle	Last
4. DATE OF DEATH OCTOBER 8, 1956 19	Month	Day	Year
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 17, 1883
9. AGE (In years last birthday) 73 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND.
12. CITIZEN OF WHAT COUNTRY? USA	13. FATHER'S NAME KARL HORMANN		
14. MOTHER'S MAIDEN NAME ELIZABETH	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. 215 03 3781	17. INFORMANT MRS ELIZABETH HORMANN	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO myocardial infarction		INTERVAL BETWEEN ONSET AND DEATH 6 hrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO Coronary arteriosclerosis (c)		? yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>march</u> , 19 <u>56</u> , to <u>10/8</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>10/1</u> , 19 <u>56</u> , and that death occurred at <u>4 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Platt</i>	M.D.	ADDRESS (Street, city or town, state) <u>434 Eastern Ave</u>	
PHYSICIAN'S NAME (Type) J. PLATT, M.D.	DATE SIGNED <u>Casey, M.D.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF OCT. 11, 56	22c. NAME OF CEMETERY OR CREMATORIUM OAK LAWN CEMETERY	22d. LOCATION (City, town, or county) BALTIMORE MARYLAND.
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Sander</i>	ADDRESS HENRY SANDER & SONS INC BALTIMORE MD.	24a. REC'D BY REGISTRAR DATE 11/11/1956	24b. REGISTRAR'S SIGNATURE <i>Edith Hurley</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit Permit. Then please reseal carbon papers. It should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

INSTRUCTIONS

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10026

CERTIFICATE OF DEATH

Reg. Dist. No. 39

10051

ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY STREET ADDRESS (If rural give location)
Baltimore Montgomery	lifetime	Md Montgomery	Baltimore Crish Ave.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Crish Ave.		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Rosalben Cecilia Houck		(Middle)	(Last) Oct 14
S. SEX Female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July 5 1873
9. AGE last birthday 83 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife	10b. KIND OF BUSINESS OR INDUSTRY house	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Leather Meredith Birmingham		
14. MOTHER'S MAIDEN NAME Alberta Hawkins	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No		
16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS Son Howard Houck, Rockville Md.		
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (A) Cerebral thrombosis (B) Arteriosclerosis cardio-vascular (C) disease		5 days 6 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 10, 1956, to Oct 14, 1956, that I last saw the deceased alive on Oct 10, 1956, and that death occurred at 104 M, from the causes and on the date stated above. SIGNATURE Elizabeth B. Henrich			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 10-17-56	NAME OF CEMETERY OR CREMATORIAL West Liberty	LOCATION (City, town, or county) White Hall, Md. (State)
24. REC'D BY REGISTRAR DATE 10/16/56	REGISTRAR'S SIGNATURE Elizabeth Houck	25. FUNERAL DIRECTOR'S SIGNATURE L. Scott Brooks, Sharpe, Md.	ADDRESS

BUREAU V. S.

OCT 17 1956

REGELYÉD

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9973 CERTIFICATE OF DEATH

10027

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland		b. COUNTY		Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6825 Holabird Ave.				6825 Hoslabird Ave.								
3. NAME OF DECEASED (Type or print)		First LIZZIE	Middle P.	Last HUGHES	4. DATE OF DEATH	Month October 23,	Day 19	Year 56				
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Nov. 15, 1868		9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.						
13. FATHER'S NAME William Porter		14. MOTHER'S MAIDEN NAME Rebecca Collins										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Howard P. Hughes 2 Winona Ave-22						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Mc SENTERIC Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH 50 hrs												
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Hypertension & A-s-Cardio Vascular Disease</u> 15 yrs												
DUE TO (c) <u>Atrial Fibrillation</u> 1 mo -												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
Chronic Renal Cholesterosis		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>										
21. I certify that I attended the deceased from Oct. 23, 1956, to Oct. 23, 1956, that I last saw the deceased alive on Oct. 23, 1956, and that death occurred at 12:45 P.M. from the causes and on the date stated above.												
ADDRESS (Street, city or town, state) M.D. 6800 Maryland Avenue 10/13/56												
DATE SIGNED												
ACTUAL SIGNATURE <u>M.B. Davis</u>												
PHYSICIAN'S NAME (Type) <u>M.B. DAVIS M.D.</u>												
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn		22d. LOCATION (City, town, or county) Colgate, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ullrich Funeral Home 2112 Dundalk Ave.												
VS A15 (4) 1SM 9/55		24a. REC'D BY REGISTRAR DATE Oct. 24, 1956		24b. REGISTRAR'S SIGNATURE John Kelly								

BUREAU Y.

OCT 25 1956

RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10028

Reg. Dist. No.

9982

47

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.
 FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Halethorpe		c. STATE AND COUNTY	
c. LENGTH OF STAY IN lb				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		3630 Washington Blvd		d. STREET ADDRESS	
e. NAME OF DECEASED (Type or print)		First Adelle	Middle Hundley	Last	4. DATE OF DEATH
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)
Female Col		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 3 1897	64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife				Accredia	
13. FATHER'S NAME		14. MOTHER'S MADDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Lobis Stewart		Fruse Cook		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Alice Hundley Wash Blvd	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)		acute Cardiac failure			
443X					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) Hypertension Cardiac vascular disease			
DUE TO					
{ (b) DUE TO					
{ (c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
19				20f. (City or town) Harmonie Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED Oct 22 56			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL SYKES CEM	
Burial Oct 22 56				22d. LOCATION (City, town, or county) Harmonie Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR 22 1956	
Mrs. Walter R. Williams		329 97 Schroeder St		24b. REGISTRAR'S SIGNATURE Dr. L. M. Kieffer	
VS. A15ME(5) 5M 9/55		DATE			

BUREAU V. 3

956 83 1

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10029

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 28 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mission Helpers Convent, 1001 W. Joppa Rd.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. STREET ADDRESS 1001 West Joppa Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Sister Mary Providencia	Middle (Hurley)	4. DATE OF DEATH MEXXEX 10/9/56
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH March 22, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nun	10b. KIND OF BUSINESS OR INDUSTRY Convent	11. BIRTHPLACE (State or foreign country) County Cork, Ireland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Hurley	14. MOTHER'S MAIDEN NAME Catherine O'Leary		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. none	17. INFORMANT Convent Records, 1001 W. Joppa Road, Towson	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 1949, to Oct. 10, 1956, that I last saw the deceased alive on Oct. 8, 1956, and that death occurred at 6 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Dr. Charles F. O'Donnell		ADDRESS (Street, city or town, state) 7501 York Road DATE SIGNED Oct. 10, 1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Oct. 12, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Convent Cemetery,
22d. LOCATION (City, town, or county) 1001 W. Joppa Rd. Towson, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE L. Vernon Lemmon		ADDRESS 4611 Park Heights Ave.	24a. REC'D BY REGISTRAR DATE Oct. 11, 1956
		24b. REGISTRAR'S SIGNATURE Mabel Graye	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it may be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

147-070

147-070

Cause

Date

Place

Name of deceased

Name of physician

Age

Date of birth

Cause

I

Name of attorney

Cause

M

Name of hospital

Name of doctor

C

Name of coroner

BUREAU V. S.

OCT 11 1956

C.O.

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10030

10053

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 929 Saint Agnes Lane		d. STREET ADDRESS 929 Saint Agnes Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Virginia		First M.	Middle Immler	Last Oct. 26, 1956	Month Oct.	Day 26	Year 1956		
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 11, 1918	9. AGE (In years last birthday) 38	10. IF UNDER 1 YEAR Months 38	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Louis Little		14. MOTHER'S MAIDEN NAME Josephine Iacovetti							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				George A. Immler, 929 St. Agnes Lane, Catonsv.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190X		Carcinoma Left Breast with Generalized Metastases							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		2 years							
(b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Balto. Md.	(County) MD	(State) MD	
21. I certify that I attended the deceased from 6/10/55 , 19, to 10/26/56 , 19, that I last saw the deceased alive on 10/26/56 , 19, and that death occurred on 10/26/56 , 19, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Balto. Md.						DATE SIGNED	
ACTUAL SIGNATURE <i>Joseph G. Laukaitis, M.D.</i>									
PHYSICIAN'S NAME (Type) JOSEPH G. LAUKAITIS, M.D.		679 WASHINGTON BLVD. BALTO. MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30/56		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral		22d. LOCATION (City, town, or county) Balto. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Harry H. Witzke</i>		ADDRESS 4101 Edmondson Ave		24a. REC'D. BY REGISTRAR Oct. 30, 1956		24b. REGISTRAR'S SIGNATURE <i>J. E. Harry</i>			

OCT 31 1956

OCT 31 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10054 CERTIFICATE OF DEATH

10031

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 28yr7m19dys		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown, Maryland		d. STREET ADDRESS Ridge Rd. - Rt. #1-Reisterstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First George	Middle RAYMOND	Last Jackson	4. DATE OF DEATH	Month October	Day 7	Year 19 56		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1892	9. AGE (In years from last birthday) 64 yrs.	IF UNDER 1 YEAR Months 64	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME James W. Jackson			14. MOTHER'S MAIDEN NAME Jane Aligire						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. unknwon	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Cardiac failure due to INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) pulmonary - hypertension (c) cardiovascular disease ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. p.m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Oct. 2, 1956 , to 10-7-56 , that I last saw the deceased alive on 10-7-56 , and that death occurred at 4:00 P.M. , from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED									
ACTUAL SIGNATURE Stella Wachsler	M.D.								
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	Catonsville 28, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) CREM	22b. DATE THEREOF Oct. 9, 1956	22c. NAME OF CEMETERY OR CREMATORIUM ARCADIA LUTHERAN CEM.	22d. LOCATION (City, town, or county) ARCADIA, BALTIMORE, MD.	(State)					
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons	ADDRESS Towson, Md.	24a. REC'D BY REGISTRAR Oct. 9, 1956	24b. REGISTRAR'S SIGNATURE E. Harry						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 3, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

OCT 9 1956

REGELY ED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained by your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10032

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i>	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgate</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>7531 Durwood Rd.</i>	d. STREET ADDRESS <i>7531 Durwood Rd.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Minnie Delmar Joiner</i>	First Middle Last	4. DATE OF DEATH <i>OCT. 13, 1956</i>				
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <i>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 14, 1886</i>	9. AGE (In years last birthday) <i>69 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>Kent Co., Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>Benjamin Sewell</i>	14. MOTHER'S MAIDEN NAME <i>Unknown Unknown</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>215-05-9398</i>	17. INFORMANT <i>Mr. John Joiner</i>	Address <i>7531 Durwood Rd</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i>						
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension C-V. Disease</i>						
DUE TO (c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Injury</i>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE <i>M.B. Davis</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					DATE SIGNED <i>10/17/56</i>
EXAMINER'S NAME (Type) <i>M. B. Davis M.D.</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Oct. 16, 1956</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Moreland Memorial Park</i>	22d. LOCATION (City, town, or county) <i>Baltimore, Md</i>	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Funeral Home</i>	ADDRESS <i>7401 Belair Rd.</i>	24a. REC'D BY REGISTRAR <i>DATE OCT 17 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Tom. M. Kelly, Jr.</i>			

BUREAU V. A

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10033

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 1533 Knecht Ave				d. STREET ADDRESS 1533 Knecht Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Elizabeth A. Kahmer		First	Middle	Lost	4. DATE OF DEATH Oct. 4, 1956	Month	Day	Year 19
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1878	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Conrad Plock		14. MOTHER'S MAIDEN NAME Bertha						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. no ne		17. INFORMANT Louis V. Kahmer, 1533 Knecht Ave		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion						INTERVAL BETWEEN ONSET AND DEATH instantaneous		
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Arteriosclerotic C.V.D.		(b)						
DUE TO		DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 206 S-Gilmor st.		(County) Baltimore (State) Md.
21. I certify that I attended the deceased from 1-1-46 , 19____, to 10-4-56 , 19____, that I last saw the deceased alive on 9-25-56 , 19____, and that death occurred at 400 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 206 S-Gilmor st. Baltimore Md.		DATE SIGNED 10-5-56
ACTUAL SIGNATURE Nathan Racusin								
PHYSICIAN'S NAME (Type) NATHAN RACUSIN								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-56		22c. NAME OF CEMETERY OR CREMATORIUM Mt. Carmel		22d. LOCATION (City, town, or county) Baltimore		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard, 4107 Wilkens Ave		ADDRESS 0078 1956		24a. REC'D BY REGISTRAR DATE 0078 1956		24b. REGISTRAR'S SIGNATURE Dr. Guston Kelley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be delivered for use as the burial-transit permit. Then please remove carbon paper. Lines 1 and 2 should be filed with the register prior to burial, cremation, or removal, and in any event within 72 hours after death.

MISSOURI STATE DEPARTMENT OF HEALTH - GAITHERSBURG - 78

CERTIFICATE OF DEATH

BUREAU V.E.

OCT 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10034

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b 82 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Westchester Avenue		d. STREET ADDRESS Westchester Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) CHARLES MICHAEL KAISER		First CHARLES	Middle MICHAEL	Last KAISER	4. DATE OF DEATH Oct. 2nd., 1956	Month Oct.	Day 2nd.	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 3, 1874	9. AGE (In years less birthday) 82 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Baltimore Co.		10b. KIND OF BUSINESS OR INDUSTRY Roads Dept.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Michael Kaiser		14. MOTHER'S MAIDEN NAME Mary Yath						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Anna Kaiser		Address Westchester Ave. Ellicott City Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		ARTERIOSCLEROSIS CRASSO-OBSCURA						
432.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO DISEASE						
{		(b) PULMONARY EDEMA						
{		DUE TO PNEUMONITIS						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Ellicott City	(County) Ellicott City	(State) Md.
21. I certify that I attended the deceased from		9/21 , 1956, to		10/2 , 1956		that I last saw the deceased alive on 10/2 , 1956, and that death occurred at 12:10 PM , from the causes and on the date stated above.		
ACTUAL SIGNATURE <i>John W. Shaw</i>		M.D.		ADDRESS (Street, city or town, state) 2800 Edmonson Ave. Ellicott City		DATE SIGNED 10/2/56		
PHYSICIAN'S NAME (Type) John W. Shaw M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/56		22c. NAME OF CEMETERY OR CREMATORIUM Good Shepherd		22d. LOCATION (City, town, or county) Ellicott City, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Eastern Sons</i>		ADDRESS Catonsville, Md.		24a. REC'D BY REGISTRAR VE. Harry		24b. REGISTRAR'S SIGNATURE		
				DATE 10-4-56				

BUREAU U.S.
T 8 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10035

Reg. Dist. No.

10057

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained by your funeral director for your records. Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with me registrar. To burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock		b. COUNTY Baltimore	
c. LENGTH OF STAY IN lb Woodstock College		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Woodstock College		d. STREET ADDRESS Woodstock College	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jerome	Middle T. Kane Sr.	Last 4. DATE OF DEATH October 31
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 31, 1893
9. AGE (In years last birthday) 63	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. yrs. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist at Woodstock College	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Bartholomew, Kane	14. MOTHER'S MAIDEN NAME Mary Nallen		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-03-8347	17. INFORMANT Jerome T. Kane Jr.	Address 1506 North Rolling Road, Baltimore
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage INTERVAL BETWEEN ONSET AND DEATH unknown 783.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> none	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) none
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>D. D. Caples</i>	DATE SIGNED 11-1-56		
EXAMINER'S NAME (Type) D. D. Caples, M. D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 3, 1956	22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE G. Howard Strong, Baltimore, Md.	ADDRESS 1207 W. North Ave.	24a. REGD BY REGISTRAR Nov. 5, 1956	24b. REGISTRAR'S SIGNATURE <i>Dr. Van. E. Martin</i>

WILSON COUNTY STATEMENT OF DEATH
DEATH EXAMINER'S CERTIFICATE

BUREAU V. S.

NOV 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10036 30				
10058 CERTIFICATE OF DEATH										Reg. Dist. No.				
1. PLACE OF DEATH a. COUNTY BALTO.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE					c. LENGTH OF STAY IN 1b 42 yrs. 3 mo					b. COUNTY Md., Balt.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Grove Hospital					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE					d. STREET ADDRESS				
3. NAME OF DECEASED (Type or print) MARY					4. DATE OF DEATH 10 - 7 - 1956					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
First A.		Middle KEIDEL		Last		Month		Day		Year				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 9/10/1878		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10b. KIND OF BUSINESS OR INDUSTRY housewife					11. BIRTHPLACE (State or foreign country) Md.				
12. CITIZEN OF WHAT COUNTRY? USA														
13. FATHER'S NAME George Frazier					14. MOTHER'S MAIDEN NAME Mary Lauter					Address Finksburg Md.				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. NONE					17. INFORMANT Mrs. Agnes Frazier				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X										INTERVAL BETWEEN ONSET AND DEATH				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)														
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 7-1-1914 to 10-7-1956 that I last saw the deceased alive on 10-7-1956 , and that death occurred at 4 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE David Edwards M.D.										ADDRESS (Street, city or town, state) DAVID E. EDWARDS				
PHYSICIAN'S NAME (Type) DAVID E. EDWARDS										DATE SIGNED 10-7-56				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL					22b. DATE THEREOF 10/2/56					22c. NAME OF CEMETERY OR CREMATORIUM Towson Cemetery				
23. FUNERAL DIRECTOR'S SIGNATURE J. Ticknor & Sons										24a. REC'D. BY REGISTRAR VS A15 (4) 15M 9/55				
ADDRESS 10058 Spring Grove Hospital Catonsville										DATE 10/2/56				
24b. REGISTRAR'S SIGNATURE J. E. Harry														

HAWAII STATE DEPARTMENT OF HEALTH - DIVISION OF
CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

8201

DECEASED

NAME OF DECEASED

DEATH DATE

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

BUREAU U. S.

OCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10037

Reg. Dist. No.

10059

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. Items 1 and 2 with a burial-transit permit. Items 1 and 2 with a cremation permit.

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT (19) LIFE		c. LENGTH OF STAY IN 1b c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 628 E ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle DAILEY	Last KELLY
4. DATE OF DEATH	Month OCT.	Day 27	Year 1952
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 8, 1914
9. AGE (In years last birthday) 41 yrs.	10. IF UNDER 1 YEAR Months —	11. IF UNDER 24 HRS. Days —	12. IF UNDER 24 HRS. Hours —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME HENRY DAILEY	14. MOTHER'S MAIDEN NAME NORMA BOTTOMSTONE		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) NO	16. SOCIAL SECURITY NO. 213-07-6198	17. INFORMANT EDW. J. KELLY	Address SAME
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary DUE TO Occusion INTERVAL BETWEEN ONSET AND DEATH 1 hr			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Jack C. Collins	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) JACK C. COLLINS	DATE SIGNED 10-29-52		
22a. BURIAL, CREMATION OR REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-30-52	22c. NAME OF CEMETERY OR CREMATORIUM OAK LAWN	22d. LOCATION (City, town, or county) BALTO. CO., MD (State)
23. FUNERAL DIRECTOR'S SIGNATURE Walter John Bradley, Reudolph, MD	ADDRESS 144	24a. REC'D BY REGISTRAR DATE 30 1952	24b. REGISTRAR'S SIGNATURE Lawrence L. Farber

WISCONSIN STATE EXAMINER'S CERTIFICATE OF DATA
VOLUME 1

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FBI - MILWAUKEE

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INDEXED

SERIALIZED

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FBI - MILWAUKEE

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10038

Reg. Dist. No.

10060

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.		b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2525 Windsor Road		d. STREET ADDRESS 2525 Windsor Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Leona Grace Kersey		First Leona	Middle Grace	Last Kersey	4. DATE OF DEATH 10/16/1956	Month 10	Day 16	Year 1956	
S. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 7 1878	9. AGE (In years lost birthday) '77 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas E. Grace		14. MOTHER'S MAIDEN NAME Susan R. Preston							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Raymond L. Grace		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1		Arterosclerotic C.V. Disease				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO							
{ DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore		(County) Md.	(State) Md.
21. I certify that I attended the deceased from 10/14 , 19 56 , to 10/16/56 , that I last saw the deceased alive on 10/13 , 19 56 , and that death occurred at 500 P.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE Nothen Janney		M.D.							
PHYSICIAN'S NAME (Type) 7101 Halford Rd.		Baltimore, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Ht. Olivet Cemetery		22d. LOCATION (City, town, or county) St. Michaels, Md.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. Hambleton		ADDRESS Harrison St. Michaels, Md.		24a. REC'D BY REGISTRAR Date		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1950

MARSHALL

RECEIVED
BUREAU V.
DEC 22 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10039

10061

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 86 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ODENTON		d. STREET ADDRESS WAUGH CHAPEL ROAD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION VETERANS ADMINISTRATION HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JEREMIAH		First (NMI)	Middle KIAH	Last KIAH	4. DATE OF DEATH OCTOBER	Month 10,	Day 19 56	Year	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-22-92	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY JANITOR, PLASTIC CO.		11. BIRTHPLACE (State or foreign country) CAMBRIDGE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN KIAH		14. MOTHER'S MAIDEN NAME JULIA MYSTER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WW-1 218-10-2887		17. INFORMANT CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X CARCINOMA, RIGHT LUNG WITH GENERALIZED METASTASIS						INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. p.m. 19	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH, FORT HOWARD, MARYLAND	(County)	(State)	
21. I certify that I attended the deceased from July 16, 1956 , to Oct. 10, 1956 , and that death occurred at 6:05 P.M. from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND									
DATE SIGNED 10/11/56									
ACTUAL SIGNATURE <i>Irving Freeman</i>		PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/15/56		22c. NAME OF CEMETERY OR CREMATORIUM BALTIMORE NATIONAL		22d. LOCATION (City, town, or county) BALTIMORE MARYLAND		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE CHARLES R LAW MORTUARY		ADDRESS 802-04 MADISON AVE BALTO		24a. REC'D BY REGISTRAR Dawson L. Farley		24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 & 2 should be filed with the registrar.
 VS A15 (4)
 15M 9/55

CERTIFICATE OF DEATH

REG. NO. 442

BUREAU V. S.
RECEIVED
OCT 17 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10040

10062

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY			BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b			b. COUNTY				
54 MIDDLE RIVER						VIRGINIA				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
oo						PARKSLEY				
d. STREET ADDRESS						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
BEULAH					KILLIMON	OCTOBER	12		19 56	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday) yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE			DEC. 15, 1893	62	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY	
HOUSEWIFE			*****			PARKSLEY, VIRGINIA			U.S.A.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME							
JOHN WILLIAM ONLEY			HENRIETTA NORTHAM							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address	
NO						MR. NOAH KILLMON			PARKSLEY, VIRGINIA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF BREAST INTERVAL BETWEEN ONSET AND DEATH 170X 3 yrs										
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from alive on			Sep 1, 1956, Oct 12, 1956, that I last saw the deceased alive on							
ACTUAL SIGNATURE			ADDRESS (Street, city or town, state)							DATE SIGNED
PHYSICIAN'S NAME (Type)			805 FUSELAGE AVE, MIDDLE RIVER, MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL			22d. LOCATION (City, town, or county)			(State)
REMOVAL		TO-T2-56		PARKSLEY BAPTIST			PARKSLEY, VIRGINIA.			
23. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS			24a. REC'D BY REGISTRAR			24b. REGISTRAR'S SIGNATURE	
Wm J. JICKNER and Sons, Belto, 17. Md.			North & Pa. Ave.			OCT 15 1956			H. L. Harles	

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.

NO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

0000

BUREAU
REC'D 15 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 3, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10041

10063

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gatonsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 3612 Woodbine Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5743 Edmondson Ave. Ridgeway Manor Nurs. Ho.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First JACOB	Middle	Last KING	4. DATE OF DEATH Oct. 3, 1956	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Apr. 1, 1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Jacob King			14. MOTHER'S MAIDEN NAME Jeannette (unknown)					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-03-3540		17. INFORMANT Mr. Charles Stallings		Address 3612 Woodbine Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Infirmittee of Age						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Generalized Arteriosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I attended the deceased from 10 - 10 - 3 , 1956, to 10 - 3 , 1956, that I last saw the deceased alive on 10 - 2 , 1956, and that death occurred at 9:45 AM , from the causes and on the date stated above.								
ACTUAL SIGNATURE Dr. Thomas G. Abbott						ADDRESS (Street, city or town, state) 4509 Liberty Heights, BALTO MD		
PHYSICIAN'S NAME (Type) DR Thomas G Abbott						DATE SIGNED 10-5-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/56		22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cem.		22d. LOCATION (City, town, or county) Woodlawn, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Schlesinger & Sons - Balt. 17th		ADDRESS 10063		24a. REC'D BY REGISTRAR Oct 6 1956		24b. REGISTRAR'S SIGNATURE R. W. E. Barry		

MISSOURI STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1968

NAME OF DECEASED	AGE AT DEATH	PLACE WHERE DEATH OCCURRED
WILLIAM H. COOPER	65	HOSPITAL
ADDRESS OF DECEASED		
1015 N. 12TH ST.		
ST. LOUIS, MO.		
NAME AND ADDRESS OF PHYSICIAN		
DR. JAMES M. COOPER 1015 N. 12TH ST. ST. LOUIS, MO.		
NAME AND ADDRESS OF FUNERAL DIRECTOR		
H. W. COOPER 1015 N. 12TH ST. ST. LOUIS, MO.		
NAME AND ADDRESS OF CEMETERY		
CITY CEMETERY 1015 N. 12TH ST. ST. LOUIS, MO.		
TIME OF DEATH		
10:00 A.M.		
CAUSE OF DEATH		
COPD		
METHOD OF DEATH		
NATURAL		
TIME OF REPORT		
10:00 A.M.		
SIGNATURE OF CLERK		
J. R. COOPER		
STAMP OR SIGNATURE OF DIRECTOR		
H. W. COOPER		
RECEIVED		
FEBRUARY 1956		

MARYLAND STATE DEPARTMENT OF HEALTH

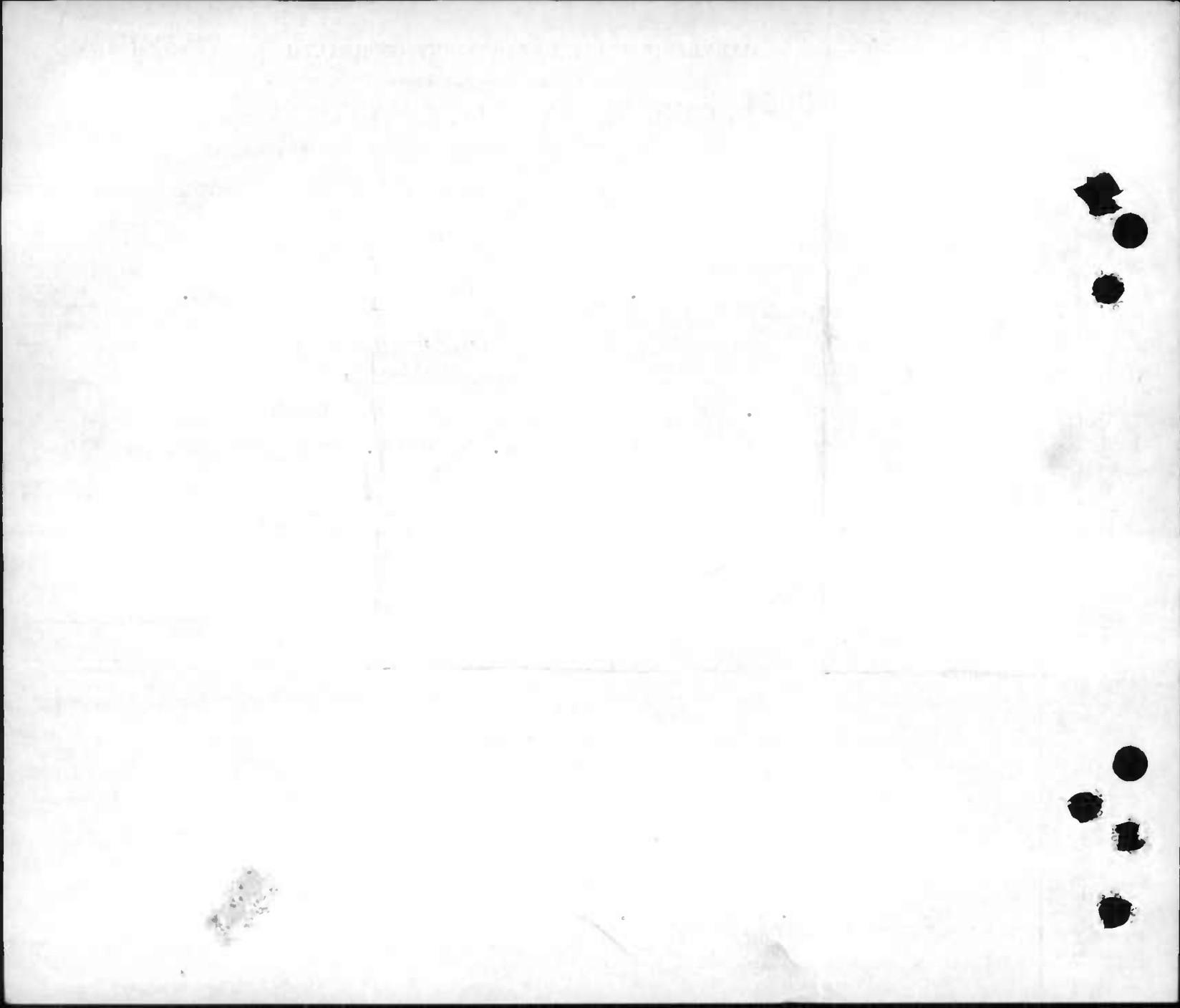
2411 N. Charles Street, Baltimore

10042

10064 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY		Baltimore	MARYLAND	Md	2. USUAL RESIDENCE (HOME) OF DECEASED STATE		Maryland	COUNTY
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Towson	LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Mercy Villa		STREET ADDRESS		Ambassador Apts		3 YO1-4
3. NAME OF DECEASED (Type or Print)	(First) Agnes	(Middle) G.	(Last) Kirby	4. DATE OF DEATH	Oct.	(Month) 30	(Day)	(Year) 1956
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. If under 1 year Months	11. If under 24 hrs. Days	12. If under 24 hrs. Hours	13. If under Min.
Female	White	Single	Feb. 11, 1882	74	yr.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
None				Baltimore, Md				
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Joseph H. Kirby		Mary FitzPatrick						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		18. MEDICAL CERTIFICATION		
				Mr. Raymond A. Kirby 1927 Park Ave				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) Pneumonia, congestive heart failure cerebral vascular accident, thrombosis					2-3 days	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Hypertension, arterio-occlusive, Thyocarditis					General	
		(c)					"	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?				
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY)		(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?				
22. I hereby certify that I attended the deceased from July 1945, to Oct 30, 1957, that I last saw the deceased alive on Oct 30, 1956, and that death occurred at 8:45 P.M., from the causes and on the date stated above. SIGNATURE <i>J.W. Ready</i> (Degree or title) ADDRESS DATE SIGNED								
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF Nov. 2, 1956		NAME OF CEMETERY OR CREMATORIAL St. Mary's Govans		LOCATION (City, town, or county) Baltimore, Maryland		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS <i>H.W. Meares Son 805 1/2 Calvert St.</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9974

CERTIFICATE OF DEATH

10043

Reg. Dist. No.

41

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNS	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22	c. LENGTH OF STAY IN 1b 2 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 25	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8219 Dogwood Drive		d. STREET ADDRESS #1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First HARRY	Middle FRANK	Last KLAUS, SR.
4. DATE OF DEATH 10-19-56	Month Day Year	10 19 56	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 8, 1881
9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
13. FATHER'S NAME JACOB	14. MOTHER'S MAIDEN NAME KLAUS	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 196-10-3666		17. INFORMANT MILDRED E. LOGAN	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Address 311 OAKSIDE DR. DUNDALK 22	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
(b) arteriosclerotic heart disease		1953	
DUE TO (c) Lest hydrounephrosis		1954	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month Oct	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 28 , 1956, to Oct 19 , 1956, that I last saw the deceased alive on Oct 19 , 1956, and that death occurred on Oct 19 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 7001 Marylanders Rd. Dundalk, Md		DATE, SIGNED	
ACTUAL SIGNATURE Eugene F Nevy	PHYSICIAN'S NAME (Type) Eugene F Nevy M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-22-56	22c. NAME OF CEMETERY OR CREMATORIAL ST. JOSEPHS	22d. LOCATION (City, town, or county) LANCASER (State) PENNS
23. FUNERAL DIRECTOR'S SIGNATURE Walter Bush Shadley, Dundalk, Md	ADDRESS	24a. REC'D. BY REGISTRAR DATE 1221956	24b. REGISTRAR'S SIGNATURE Mar Kelly

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
OCT 22 1956

1

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10065 CERTIFICATE OF DEATH**

10044

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reistersdorf Rural</i>		c. LENGTH OF STAY IN 1b <i>48 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reistersdorf Rural</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Pleasant Grove</i>		d. STREET ADDRESS <i>Pleasant Grove</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Rosa.</i>		First <i>Anr.</i>	Middle <i>Kerman</i>	Last <i>Kerman</i>	4. DATE OF DEATH <i>October 25 1956</i>	Month <i>October</i>	Day <i>25</i>	Year <i>1956</i>
S. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>January 24, 1875</i>	9. AGE (In years last birthday) <i>81 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William Brathwaite</i>		14. MOTHER'S MAIDEN NAME <i>Sophia Duce</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		
17. INFORMANT <i>Bessie Kerman Reistersdorf Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>H22.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH <i>None Myocarditis</i>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		
21. I certify that I attended the deceased from <i>August 15 1956</i> to <i>Oct 25 1956</i> , that I last saw the deceased alive on <i>October 22 1956</i> , and that death occurred at <i>9A.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Joseph E. Bush</i> PHYSICIAN'S NAME (Type) <i>Joseph E. Bush MD</i>		22. DATE OF INJURY Month, Day, Year Hour a. m. _____ 19 p. m. _____		23. DATE OF INJURY White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hampstead Md</i>		
25. TIME OF INJURY Hour a. m. _____ 19 p. m. _____		26. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>		27. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hampstead Md</i>		28. (City or town) (County) (State) <i>Hampstead Md</i>		
29. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		30. DATE THEREOF <i>Oct 27 1956</i>		31. NAME OF CEMETERY OR CREMATORIUM <i>Pleasant Grove</i>		32. LOCATION (City, town, or county) <i>Baltimore Md</i>		
33. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Gipton Hampstead Md</i>		34. ADDRESS <i>Hampstead Md</i>		35. REC'D BY REGISTRAR DATE <i>10-26</i>		36. REGISTRAR'S SIGNATURE <i>Mary B Elmer</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be referred by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's file, it should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and in any event within 72 hours after death.
 The registrar prints to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FBI
RECEIVED
OCT 30 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9975

CERTIFICATE OF DEATH

10045

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
Baltimore MARYLAND		a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8201 Long Point Road		d. STREET ADDRESS 8201 Long Point Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LOUIS	Middle C.	Last KURZMILLER
4. DATE OF DEATH	Month October	Day 5	Year 19 56
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DEC 3, 1902
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Bethelhem Steel Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME Charles Kurzmiller		14. MOTHER'S MAIDEN NAME Antona Kreiner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No. 216-09-6761	
17. INFORMANT		Address Mrs. Alice Kurzmiller 8201 Long Point Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Inj	
20c. TIME OF INJURY Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) Parkville, Md. (Baltimore Co.) (Md.)
21. I certify that I attended the deceased from MARCH 4, 1955, to Oct. 5, 1957, that I last saw the deceased alive on Oct. 1, 1956, and that death occurred at 3:00 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE M.B. Davis PHYSICIAN'S NAME (Type) M.B. Davis M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Moreland Park
22d. LOCATION (City, town, or county) Parkville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 2112 Dundalk Ave.		24a. REC'D BY REGISTRAR DATE Oct 10 1956	24b. REGISTRAR'S SIGNATURE John P. Kelly

CERTIFICATE OF DEATH

SAC 4040

MD 505428

DECEASED

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
EDWARD J. KELLY	50	M	HEART DISEASE
ADDRESS	STREET	CITY	STATE
101 E. BELMONT	ST.	BALTIMORE	MARYLAND
PHONE NUMBER	EXCHANGE	NUMBER	
410-555-1234	555	1234	
DATE OF DEATH	TIME	DAY	MONTH
NOVEMBER 10, 1956	10:00 AM	MONDAY	NOVEMBER
DECEASED'S WEIGHT	HEIGHT	HAIR COLOR	EYE COLOR
180 lbs	5'10"	BLACK	BLUE
RELIGION	EDUCATION	EMPLOYMENT	HOBBIES
CATHOLIC	COLLEGE	TEACHER	GOLF
INTERVIEWER'S SIGNATURE	INTERVIEWER'S NAME	INTERVIEWER'S TITLE	INTERVIEWER'S ADDRESS
RECEIVED	DET. 10 10 1956	SAC 4040	

INSTRUCTIONS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10046

Reg. Dist. No. 31

10066

1. PLACE OF DEATH

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL
OR end give nearest town)

TOWN COCKEYSVILLE

LENGTH OF STAY
(in this place)

17 YEARS

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

MASONIC HOME

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE MD

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN EASTON

STREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First) HARVEY

(Middle)

(Last)

LEONARD

4. DATE (Month)
OF
DEATH

10 1 19 56

5. SEX

M

6. COLOR OR
RACE

W

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

WIDOWED

8. DATE OF BIRTH

9/28/1873

9. AGE at birthday
yrs.

83

10. IF UNDER 1 YEAR
Months Deys Hours Min.10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

DENTIST

10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

TALBOT COUNTY, MD

12. CITIZEN OF WHAT
COUNTRY?

US

13. FATHER'S NAME

JONATHAN HADAWAY LEONARD

14. MOTHER'S MAIDEN NAME

ANNA MATILDA NEUNAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT & ADDRESS

Frank L. Smith Jr.
Cockeysville, Md.INTERVAL BETWEEN
ONSET AND DEATH

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE

(A)

DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Papers may be retained by your firm or removed by your funeral director. Page 3 should be used as a burial-transit permit. File page 1 and 2 with your registrar.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10047

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
<i>Baltimore Co.</i> MARYLAND		a. STATE Maryland	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Towson</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Mill Dam Road near Seminary Avenue		55	
3. NAME OF DECEASED (Type or print)		First <i>P</i> Robert	Middle <i>J.</i> Leonard
4. DATE OF DEATH		Month <i>10</i>	Day <i>27</i>
5. SEX		Year <i>1956</i>	
6. COLOR OR RACE		9. AGE (In years, last birthday) <i>41</i>	10. IF UNDER 1 YEAR Months <i>4</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	11. IF UNDER 24 HRS. Days <i>0</i>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Layout Man</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bartlett - Hayward</i>	
13. FATHER'S NAME <i>James A. Leonard</i>		14. MOTHER'S MAIDEN NAME <i>Caroline Bohnet</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-07-3965</i>	
17. INFORMANT <i>Family records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Coronary Occlusion</i>	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b)	
		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>William V. Gray</i>		DATE SIGNED <i>10-28-56</i>	
EXAMINER'S NAME (Type)		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 31, 1956</i>	
		22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>	
		22d. LOCATION (City, town, or county) (State) <i>Parkville, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John Burns Sons,</i>		ADDRESS <i>Towson, Maryland</i>	
		24a. REC'D BY REGISTRAR DATE <i>10/29/56</i>	
		24b. REGISTRAR'S SIGNATURE <i>Mabel C. Gray</i>	

EXAMINER'S CERTIFICATE OF DETACHMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU U. S.

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9934

CERTIFICATE OF DEATH

10048

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Md.		b. COUNTY Baltimore																				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus		c. LENGTH OF STAY IN 1b Arbutus		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arbutus																						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 752 Beechfield Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																				
3. NAME OF DECEASED (Type or print) Margaret Anna Lewis		First	Middle	Last	4. DATE OF DEATH October 10,	Month	Day	Year 1956																		
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH July 9, 1903	9. AGE (In years lost birthday) 53 yrs.	IF UNDER 1 YEAR 33 months	IF UNDER 24 HRS. Months Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.																				
13. FATHER'S NAME Louis Doering			14. MOTHER'S MAIDEN NAME Barbara S. Limmer																							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. C16-07-2411		17. INFORMANT Howard W. Lewis		Address 752 Beechfield Avenue																				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="0"> <tr> <td colspan="2">PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)</td> <td colspan="2">Coronary Occlusion</td> <td>INTERVAL BETWEEN ONSET AND DEATH 12 hours</td> </tr> <tr> <td colspan="2">420.1</td> <td>DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)</td> <td colspan="2">Coronary artery disease</td> <td>1 yr.</td> </tr> <tr> <td colspan="2"></td> <td>DUE TO (c)</td> <td colspan="2"></td> <td></td> </tr> </table> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 12 hours	420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary artery disease		1 yr.			DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 12 hours																						
420.1		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary artery disease		1 yr.																					
		DUE TO (c)																								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <hr/>																								
20c. TIME OF INJURY Hour o. m. _____ p. m. _____	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Md.	(State) Md.																		
21. I certify that I attended the deceased from Sept 10, 1955 , to Oct 10, 1956 , that I last saw the deceased alive on Oct 10, 1956 , and that death occurred at 8:00 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE I. EARL PASS, M.D. PHYSICIAN'S NAME (Type) I. EARL PASS, M.D. ADDRESS 4001 Wilkens Ave DATE SIGNED 10-11-56																										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/13/56	22c. NAME OF CEMETERY OR CREMATORIAL Poly Redeemer Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland			(State) Md.																			
23. FUNERAL DIRECTOR'S SIGNATURE Howard N. Hubbard 4107 Wilkens Avenue			ADDRESS	24a. REC'D BY REGISTRAR DATE Oct 15 1956		24b. REGISTRAR'S SIGNATURE Dr. G. M. Kelly																				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar privately. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with the registrar privately. Burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 15 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 lines 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10068

CERTIFICATE OF DEATH

10049

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 V O I - 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 3921 Norfolk Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24			
3. NAME OF DECEASED (Type or print)	First JAKE	Middle M.	Last LIBERMAN	4. DATE OF DEATH October	Month October	Day 22	Year 1956		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH June 22, 1892	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Hours 0	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Clothing Business		11. BIRTHPLACE (State or foreign country) Ponevez, Russia		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Harry Liberman		14. MOTHER'S MAIDEN NAME Unknown							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WWI		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Fort Howard, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x		CEREBRAL THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 6 MONTHS					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) BRONCHOPNEUMONIA		8 DAYS					
DUE TO		(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. p.m. p. m.		Month 19	Day 19	Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH, FORT HOWARD, MARYLAND	(County) Maryland	(State) MARYLAND
21. I certify that <input checked="" type="checkbox"/> attended the deceased from October 16, 1956 to October 22, 1956 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND		DATE SIGNED 10/22/56	
ACTUAL SIGNATURE C. J. Papastrat MD		M.D.							
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-23-56		22c. NAME OF CEMETERY OR CREMATORIUM Hebrew Cemetery - Windsor MILL RD		22d. LOCATION (City, town, county) Baltimore, Maryland		(State) MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE Jack Lewis, Inc., 2100 Eutaw Pl., Balto., Md.		ADDRESS 0		24a. REC'D BY REGISTRAR DATE 10-24-1956		24b. REGISTRAR'S SIGNATURE Dawson L. Farber			

2000-01

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BUREAU V. S.

OCT 24 1956

РЕГЕИВ ЕД

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, lines 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, lines 1 and 3, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10069

CERTIFICATE OF DEATH

10050

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville		c. LENGTH OF STAY IN lb 1mth5dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County 28			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2129 Old Frederick Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Frederick	Middle W.	Last Link	4. DATE OF DEATH	Month October	Day 18	Year 19 56
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 16, 1884	9. AGE (In years lost birthday) 71 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Link				14. MOTHER'S MAIDEN NAME Lizzie Lacomb			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Coronary and generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary emphysema							
INTERVAL BETWEEN ONSET AND DEATH 2 weeks							
1 mth.							
years							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month Sept.	Day 13	Year 19 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore
(State) Md.							
21. I certify that I attended the deceased from Sept. 13, 19 56 to October 18, 19 56 that I last saw the deceased alive on Oct. 18, 19 56 and that death occurred at 8:30 a.m. from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL							
DATE SIGNED 10-18-56							
ACTUAL SIGNATURE <i>Charles S. Ward</i>		M.D.					
PHYSICIAN'S NAME (Type) Charles S. Ward, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/20/56	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore Cem.		22d. LOCATION (City, town, or county) Balto., Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. J. Dickner & Sons - Balt. 17 Nov 1956</i>		ADDRESS 17 Nov 1956		24a. REC'D. BY REGISTRAR DATE 22 1956		24b. REGISTRAR'S SIGNATURE <i>J. E. Harry</i>	

CERTIFICATE OF DEATH

PRINTED IN U.S.A.

NAME

ADDRESS

CITY

STATE

ZIP CODE

NO. Serial
Date of Birth
Date of Death

TIME

DEATH

AGE

SEX

WEIGHT

HEIGHT

HAIR COLOR

EYE COLOR

RELIGION

EDUCATION

OCCUPATION

MATERIALS

EXAMINER

TESTIMONY

RECEIVED

BUREAU V. A.

OCT 22 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10070 CERTIFICATE OF DEATH

10051

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cockeysville						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Warren Road			d. STREET ADDRESS Warren Road						
3. NAME OF DECEASED (Type or print) First Mary Middle M. Lintz			Last		4. DATE OF DEATH October 13, 1956		Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 4, 1881		9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Jacob Class			14. MOTHER'S MAIDEN NAME Augusta Stern						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. None		17. INFORMANT W. Ross Lintz		Address Warren Rd. Cockeysville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH none 3 years.						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Balto. Co. Md.		(County)	(State)
21. I certify that I attended the deceased from July 1950, to Oct 1956, that I last saw the deceased alive on 13 Oct 1956, and that death occurred at 7 A.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 6701 York Rd. Baltimore, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 16, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Jacksonville Reformed		22d. LOCATION (City, town, or county) Balto. Co. Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Lanahan Funeral Home		ADDRESS 7401 Belair Rd.		24a. REC'D BY REGISTRAR DATE 17 1956		24b. REGISTRAR'S SIGNATURE Anne MacPhee			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

ST 3100HAT18-10240R TO WENTLAW'S STATE CIRCUIT

RECEIVED

CT 17 1956

BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10052

10071 CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH-
CITY
COUNTY

Balto.

MARYLAND

CITY (If outside corporate limits, write RURAL and
OR give nearest town)
TOWN RaspeburgLENGTH OF STAY
(in this place)
3 yrsHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

5113 Kenwood Ave

3. NAME OF
DECEASED
(Type or Print)

(First) Joseph (Giuseppe) (Middle) Mangano

2. USUAL RESIDENCE (HOME) OF DECEASED-
STATE

Md.

COUNTY

4. SEX

Male

6. COLOR OR RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED.
(Specify)

Married

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

Kenwood

(If rural, give location)

5113 Kenwood Ave

4. DATE
OF
DEATH

Oct 28

1956

8. DATE OF BIRTH

Apr. 16 1891

65

yrs.

If under 1 year
Months Days Hours Min.

If under 24 hrs.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

22005

10b. KIND OF BUSINESS OR
INDUSTRY

S-17

11. BIRTHPLACE (State or foreign country)

Italy

12. COUNTRY OF WHAT

U.S.A.

13. FATHER'S NAME

John Mangano

14. MOTHER'S MAIDEN NAME

Angelina Parisi

15. WAS DECEDER EVER IN U.S. ARMED FORCES?

No

(Yes, no, or unknown) (If yes, give war or dates of
service)

16. SOCIAL SECURITY NO.

018-32-1011

17. INFORMANT AND ADDRESS

Angelina Mangano 5113 Kenwood

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443X Immediate cause

(a) Hypertensive Arterosclerotic C.V.D. 10 yrs

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) _____

(c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

INTERVAL BETWEEN
ONSET AND DEATH21. ACCIDENT
SUICIDE
HOMICIDE
(Specify)PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work m. Not While At work

HOW DID INJURY OCCUR?

m.

DATE SIGNED

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

22. I hereby certify that I attended the deceased from

June 1959

, to Oct 28, 1956

, 1956, and that death occurred at

250 p.m.

, from the causes and on the date stated above.

ADDRESS

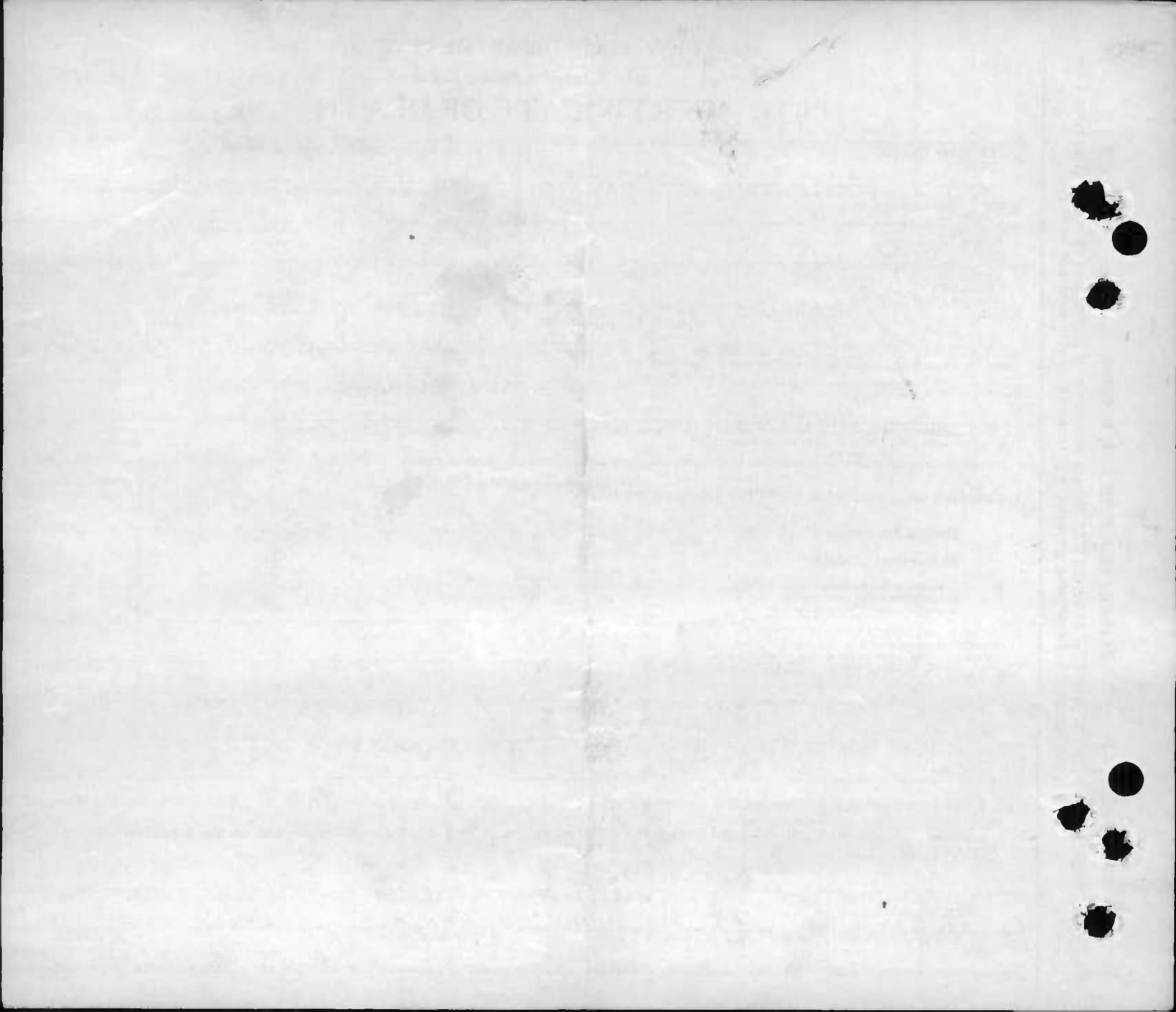
10/29/56

DATE SIGNED

VS. A. B. C. D. E. F. G. H. I. J. K. L. M. N. O. P. Q. R. S. T. U. V. W. X. Y. Z.

10/29/56

DATE SIGNED



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10053
10

10072

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. It should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b lyrlllmt25dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Altamont Hotel - Eutaw & Lanvale Sts		e. IS RESIDENCE ON A FARM? No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Ida	Middle Mae	Last Marshall	4. DATE OF DEATH	Month October	Day 29,	Year 19	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 8, 1882	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME James F. Johnson				14. MOTHER'S MAIDEN NAME Sally Elizabeth Tull				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c) Dehydration INTERVAL BETWEEN ONSET AND DEATH <i>422.1</i>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Debility - Decubital sores 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —						
20c. TIME OF INJURY Hour a. m. p. m.	Month Oct. 3,	Day 19	Year 56	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) Oct. 29,	(County) 1956	(State) —
21. I certify that I attended the deceased from Oct. 3, 1956 , to Oct. 29, 1956 , that I last saw the deceased alive on Oct. 29, 1956 , and that death occurred at 8:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 10-29-56 DATE SIGNED 10-29-56								
ACTUAL SIGNATURE Stella Wachsler								
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/1/56	22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Episcopal Cem.		22d. LOCATION (City, town, or county) Pocomoke City, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Dickner & Sons - Baile 17 Md.			ADDRESS —	24a. REC'D BY REGISTRAR Oct. 30, 1956		24b. REGISTRAR'S SIGNATURE J. E. Harry		

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BIBLIA A.

OCT 31 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10073

CERTIFICATE OF DEATH

10054

Reg. Dist. No.

38

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 register page 3 for burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
<i>Baltimore</i>		<i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	
<i>Parkville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>2511 Hillcrest Avenue</i>		d. STREET ADDRESS <i>2511 Hillcrest Avenue</i>	
3. NAME OF DECEASED (Type or print)		First <i>Fritz</i>	Middle <i>Adolf</i>
		Last <i>Karl</i>	4. DATE OF DEATH Month <i>October</i> Day <i>19th</i> Year <i>19 56</i>
S. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 29, 1889</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
<i>Brick Mason</i>			<i>Berlin, Germany</i>
13. FATHER'S NAME <i>Adolf Martin</i>		14. MOTHER'S MAIDEN NAME <i>Johanna Cuba</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Mrs. Erna E. Martin, 2511 Hillcrest Ave.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		<i>Coronary occlusion</i>	
DUE TO (b) <i>Arteriosclerotic C.V.D.</i>			
DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19 <i>55</i> , to <i>Aug. 19</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Aug. 19, 1956</i> , and that death occurred at <i>10 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>2916 E. Cold Spring Lane</i>	
ACTUAL SIGNATURE <i>J. Henry Haase</i>		DATE SIGNED <i>14 Aug 1956</i>	
PHYSICIAN'S NAME (Type) <i>J. Henry Haase M.D.</i>		M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/22/56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Parkwood Cemetery</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #04</i>		ADDRESS <i>Leonard J. Ruck 5305 Harford Road #04</i>	24a. REG'D BY REGISTRAR DATE <i>Oct. 22, 1956 Dr. A. M. Bacon</i>
		24b. REGISTRAR'S SIGNATURE	

BUREAU V. S.

OCT 23 1956

REFUGEE ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10074

CERTIFICATE OF DEATH

10055
Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - RANDALLSTOWN		c. LENGTH OF STAY IN 1b 10 YEARS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McDONOGH RD.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle STEWART	Last McCABE
4. DATE OF DEATH	Month 10	Day 3	Year 1956
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 16 1928
9. AGE (In years last birthday) 28		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FIELD ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY FIELD ENGINEER	
11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM STANFORD McCABE		14. MOTHER'S MAIDEN NAME DOROTHY CHIDLAW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes ✓ 1948-1953		16. SOCIAL SECURITY NO. 21-26973	
17. INFORMANT MOTHER DOROTHY McCABE		Address McDonogh Rd Randallstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF COLON 153X DUE TO Conditions, if any, which gave rise to immediate cause (b), stealing the under- lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH 25 MONTHS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Aug 17 1956 to Oct. 3 1956 , that I last saw the deceased alive on Oct. 2 1956 , and that death occurred on Oct. 3 1956 M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 8204 LIBERTY RD., BALTO. MD. 10/3/56	
ACTUAL SIGNATURE <i>Eowin L. Pierpont</i>	PHYSICIAN'S NAME (Type) EOWIN L. PIERPONT, M.D.	DATE SIGNED 10/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) 8204 LIBERTY RD., BALTO. MD.	22b. DATE THEREOF 10/3/56	22c. NAME OF CEMETERY OR CREMATORIAL 8204 LIBERTY RD., BALTO. MD.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edwin L. Pierpont</i>		ADDRESS 8204 LIBERTY RD., BALTO. MD.	
		24a. REC'D. BY REGISTRAR 10/15 1956	24b. REGISTRAR'S SIGNATURE <i>He Wm Martin</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 it should be detached for use as the burial-transit permit. Then please remove carbon papers. Yes No
 and in any event within 72 hours after death.
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WATSON'S STATE PROGRAM OF HEALTH-BELIEF MODEL II

CERTIFICATE OF DEATH

BUREAU V. S
RECEIVED
OCT 5 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 3, from this certificate. The registrar prints the name of the deceased on page 3.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10075

CERTIFICATE OF DEATH

10056

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson		c. LENGTH OF STAY IN 1b 55		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		d. STREET ADDRESS Dulaney Valley Apts.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dulaney Valley Apts-900 Southerly Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First JAMES	Middle N.	Lost McCOSH, Sr.	4. DATE OF DEATH Oct. 4, 1956	Month	Day	Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 6, 1881	9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman (rtd)		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Dr. Samuel A. McCosh				14. MOTHER'S MAIDEN NAME Louise Kellog				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-18-5646		17. INFORMANT Mrs. James N. McCosh, Sr. - 900 Southerly Rd.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		CARCINOMATOSIS				INTERVAL BETWEEN ONSET AND DEATH		
DUE TO (b)		ANAPLASTIC CARCINOMA Prostate				Dec 1954		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 1951, to Oct 1956, that I last saw the deceased alive on Oct 1956, and that death occurred at 12:15 AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE W. Kennedy Waller, M.D.						DATE SIGNED 51st Cathedral St. Oct 1956		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 10/6/56		22c. NAME OF CEMETERY OR CREMATORIUM Green Mount Crematory		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Tichener & Sons - Balto 17th & Charles St. 1956		ADDRESS		24a. REC'D BY REGISTRAR Oct 6, 1956		24b. REGISTRAR'S SIGNATURE R. W. Mabel Gray		

87 - 33000000 - RELEASE TO THE PUBLIC BY STATE QUALITY ASSURANCE

BUREAU V. S.

OCT 8 1956

REGELIV ELL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10057

Reg. Dist. No.

31

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriotsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriotsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R. F. D. #1		d. STREET ADDRESS R. F. D. #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First MARY	Middle MAY	Last MENTZELL	4. DATE OF DEATH	Month Oct.	Day 18	Year 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1893	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Ewing		Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Lemuel K. Mentzell-R.F.D.#1, Marriotsville		Address Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH not known							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Randallstown	(County) Md.	(State) Md.	
21. I certify that I attended the deceased from Oct. 1st, 1956 , to Oct. 15, 1956 , that I last saw the deceased alive on Oct. 14, 1956 , and that death occurred at 8 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Wm. E. Martin ADDRESS (Street, city or town, state) Randallstown DATE SIGNED Wm. E. Martin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/56	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Balto.		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. J. Scherer & Sons - Balto. 17 Md.		ADDRESS 10076	24a. REC'D BY REGISTRAR DATE Oct. 22, 1956		24b. REGISTRAR'S SIGNATURE Dr. Wm. E. Martin		

81. ЗВОНИТЕ НАШИМ РЕДАКТОРАМ И ПРОФЕССИОНАЛАМ

BUREAU V.

OCT 23 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 Film G206 11-5-56 et

10077

CERTIFICATE OF DEATH

Reg. Dist. No.

10058

38

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from the death certificate and filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Armacost Nursing Home</i>		d. STREET ADDRESS <i>5111 Plainfield Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>Mrs. Mary</i>		First <i>y</i>	Middle <i>Milan</i>
4. DATE OF DEATH <i>October 29th 1956</i>	Month <i>October</i>	Day <i>29</i>	Year <i>1956</i>
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 21, 1881</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At Home</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Lithuania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>?</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>450.1</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mr. Matthew J. Milan, 5111 Plainfield Ave</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia, left lower lobar</i>		INTERVAL BETWEEN ONSET AND DEATH <i>(terminal) 3 days</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>Arteriosclerosis, generalized</i>			
(b) DUE TO <i>Gangrene 3rd x 4th toes left foot</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</i>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 1, 1956</i> , to <i>Oct 29, 1956</i> , that I last saw the deceased alive on <i>Oct 26, 1956</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Charles V. Sevcik M.D. 5101 Belair Rd</i>			
ACTUAL SIGNATURE <i>Charles V. Sevcik</i>		DATE SIGNED <i>10/30/56</i>	
PHYSICIAN'S NAME (Type) <i>Charles V. Sevcik</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/31/56</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR <i>DATE - 11050</i>	
ADDRESS <i>Mehlwegs</i>		24b. REGISTRAR'S SIGNATURE <i>Mehlwegs</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

BUREAU Y. S.
RECEIVED
NOV 1 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10059

10078

CERTIFICATE OF DEATH

Reg. Dist. No. 33-

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Freeland</i>		c. LENGTH OF STAY IN lb <i>66 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Freeland</i>		d. STREET ADDRESS <i>Oakland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Oakland Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Estella L. Miller</i>		First	Middle	Last	4. DATE OF DEATH <i>October 23 1956</i>	Month	Day	Year	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 12 1880</i>	9. AGE (In years last birthday) <i>76 yrs.</i>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		11c. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>Mrs. John Keeney, Freeland, Md.</i>			
13. FATHER'S NAME <i>Charles Morris</i>		14. MOTHER'S MAIDEN NAME <i>Julia Morris</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>491X</i>		17. INFORMANT <i>Mrs. John Keeney, Freeland, Md.</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronche - pneumonia</i>		DUE TO <i>491X</i>				INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Parkton, Md.</i>		20f. (City or town) <i>Parkton, Md.</i>		(County) <i>Parkton, Md.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Oct. 18, 1956</i> , to <i>Oct. 23, 1956</i> , that I last saw the deceased alive on <i>Oct. 22, 1956</i> , and that death occurred at <i>5:00 A.M.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>A. M. France</i>		ADDRESS (Street, city or town, state) <i>Parkton, Md.</i>							DATE SIGNED <i>10/23/56</i>
PHYSICIAN'S NAME (Type) <i>Dr. A. M. France</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 26, 1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>MT. Zion Cemetery</i>		22d. LOCATION (City, town, or county) <i>Freeland, Md.</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Nasolo Mortuaries, Inc. - Freedom Park</i>		ADDRESS <i>10078</i>		24a. REC'D BY REGISTRAR <i>10/26/56</i>		24b. REGISTRAR'S SIGNATURE <i>Lester L. Gedson</i>			

WISCONSIN STATE DEPARTMENT OF HEALTH - DIVISION OF

CERTIFICATE OF DEATH

BUREAU X

OCT 31 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9976

CERTIFICATE OF DEATH

1006041

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6906 SOLLERS PT. RD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22			
3. NAME OF DECEASED (Type or print) MARY SANDNER MINNICK		d. STREET ADDRESS 6906 SOLLERS PT. RD.			
3. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 8, 1873		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIF	10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JOSEPH PATRICK SANDNER	14. MOTHER'S MAIDEN NAME JOHANNA AYEYERS				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. NONE	17. INFORMANT FRANK MINNICK - 46 BROADSTWY	Address DUNDALK Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholecystitis And Hepatitis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Deputy (c)					
INTERVAL BETWEEN ONSET AND DEATH 70 days.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 6800 MORNINGTON RD	20f. (City or town) BALTO. CO., MD.	(County) Md.	(State) MD.
21. I certify that I attended the deceased from Sept. 10, 1956 to Oct. 1, 1956 , that I last saw the deceased alive on Sept. 30, 1956 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE M.B. Davis	ADDRESS (Street, city or town, state) 6800 MORNINGTON RD				DATE SIGNED 10/2/56
PHYSICIAN'S NAME (Type) M.B. DAVIS M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-4-56	22c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART OF J.	22d. LOCATION (City, town, or county) BALTO. CO., MD.	(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter George Bradley, Dundalk, MD	ADDRESS —	24a. REC'D BY REGISTRAR DATE OCT 3 1956	24b. REGISTRAR'S SIGNATURE Tom. Mc Kelly, Jr.		

CERTIFICATE OF DEATH

NAME

ADDRESS

CITY

STATE

ZIP

BUREAU V.

OCT 3 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4.
 may be retained by the hospital or attending physician.
 TO BURIAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										10061			
10079 CERTIFICATE OF DEATH										Reg. Dist. No. 45			
ITEMS 18-21: G205 10-26-56L					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)								
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND					b. STATE MARYLAND. b. COUNTY BALTIMORE								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
MIDDLE RIVER			30 Years		MIDDLE RIVER								
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 442 WHITETHORN WAY					d. STREET ADDRESS 442 WHITETHORN WAY								
3. NAME OF DECEASED (Type or print) ALEXANDER STANLEY MOCARSKY					First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.						
MALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG. 16, 1902	54 yrs.	Months	Days	Hours	Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?				
HANDYMAN			MARTIN'S			HARTFORD CONN.			USA.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME								
MOCARSKY													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.	17. INFORMANT	Address						
YES <input checked="" type="checkbox"/>					16/18/19	215 07 4914	MRS FLORENCE A. MOCARSKY	SAME.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure INTERVAL BETWEEN ONSET AND DEATH 420.0													
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic Heart disease													
DUE TO (c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)											
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)				
Hour o. p. p. m.		19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										
21. I certify that I attended the deceased from Sept. 20, 1956, to Oct. 24, 1956, that I last saw the deceased alive on Oct. 24, 1956, and that death occurred at _____, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED													
ACTUAL SIGNATURE <i>Hi Oktay</i> PHYSICIAN'S NAME (Type) HI OKTAY													
M.D. 100 N. Calhoun St.													
22a. BURIAL, CREMATION, (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
BURIAL		10/29/56		BALTIMORE NATIONAL CEM.		BALTIMORE MARYLAND.							
23. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS								
HENRY SANDER & SONS INC BALTIMORE MD.					24a. REC'D BY REGISTRAR								
					DATE 10/26/56								
					24b. REGISTRAR'S SIGNATURE <i>Cauch Wurley</i>								

BUREAU V.

OCT 29 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10080

CERTIFICATE OF DEATH

10062

Reg. Dist. No.

28

1. PLACE OF DEATH
o. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ruxton

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Lutheran Mother House3. NAME OF
DECEASED
(Type or print)

First LOUISE L. Moeller

Middle

Last

4. DATE
OF
DEATH

October 28 th. 1956

Month

Day

Year

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Aug: 8; 1866

9. AGE (In years
from last birthday)
90 yrs.

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Deaconess10b. KIND OF BUSINESS OR INDUSTRY
Lutheran Home

11. BIRTHPLACE (State or foreign country)

Washington D.C.

12. CITIZEN OF WHAT COUNTRY?
U.S.A.

13. FATHER'S NAME

John N. Moeller

14. MOTHER'S MAIDEN NAME

Louise Rauch

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

(If yes, give war or dates of service)

No.

16. SOCIAL SECURITY NO.

None

17. INFORMANT

Records-Lutheran Deaconess Home Address 1100 Boyce Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

443 X

DUE TO

INTERVAL BETWEEN
ONSET AND DEATHHypertension - Cardiac - vascular
diseaseConditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

DUE TO

(b)

(c)

MEDICAL CERTIFICATION

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, notify medical examiner)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from _____, 1939, to 10-28, 1956, that I last saw the deceased alive on 10-27, 1956, and that death occurred at 9 A.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

A. L. Ewald Jr.

M.D.

56 York Ct.

PHYSICIAN'S
NAME (Type)22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Oct. 30-1956 Rock Creek Cemetery

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

(State)

Washington D.C.

23. FUNERAL DIRECTOR'S SIGNATURE

F. D. Hibbert - Mrs. Eustace P. Gray

ADDRESS

OCT 29 1956
BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

01-3910MIL04-B-01-0001-30-7411-12-003-07A12-00-A7-0000

OCT 30 1956

BUREAU V. 2

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10081

CERTIFICATE OF DEATH

10063 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 34 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 v o 1 - 4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 307 E. Melrose Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle W	Last MORAN	4. DATE OF DEATH October 6	Month October	Day 6	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/25/97	9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months 59	IF UNDER 24 HRS. Days 59	Hours 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles E. Moran				14. MOTHER'S MAIDEN NAME Lillian M. Sullivan				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 705-09-1356		17. INFORMANT Clin. Rec. Vets. Admin.Hosp., Ft. Howard, Md.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRESH THROMBOTIC OCCLUSION RIGHT ANTERIOR DUE TO CORONARY ARTERY Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 2 HOURS		UNKNOWN		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) OLD HEALED APICAL MYOCARDIAL INFARCTION								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) old healed apical myocardial infarction						
20c. TIME OF INJURY Hour o. g. p. m.	Month September	Day 2	Year 1956	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from September 2, 1956 , to October 6, 1956 . Arthur G. Edwards saw the deceased alive on September 2, 1956 and that death occurred at 9:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Baltimore, Md.								
ACTUAL SIGNATURE <i>Arthur G. Edwards</i>	DATE SIGNED October 6, 1956							
PHYSICIAN'S NAME (Type) ARTHUR G. EDWARDS, M. D.	M.D. Veterans Administration Hospital							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-6-56	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery			22d. LOCATION (City, town, or county) Baltimore, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons, Inc.				ADDRESS 1905 York Rd., Baltimore, Md.		24a. REC'D BY REGISTRAR 0018 1956		
						24b. REGISTRAR'S SIGNATURE <i>Dorothy L. Farber</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar.

CERTIFICATE OF DEATH

WISCONSIN STATE GOVERNMENT - BUREAU OF ELECTIONS

BUREAU V.

OCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10082

CERTIFICATE OF DEATH

10064 37

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>42 Croftley Rd. Baltimore County</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>42 Croftley Road, Lutherville, Md.</i>		e. STREET ADDRESS <i>518 E. 39th St</i>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Ada May Johnson Masberg</i>		First <i>Ada</i>	Middle <i>May</i>
		Last <i>Johson</i>	4. DATE OF DEATH <i>October 25</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Nov. 24 1889</i>		9. AGE (In years lost birthday) yrs. <i>66</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>W.H. Solomon Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Amelia Adeline Johnson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>Dr Wm. Marberg 120 Hawthorne Rd. - 10</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Metastatic Ca</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>	
170X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>DUE TO</i> (b) <i>Carcinoma of Breast</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sept 9, 1956</i> , to <i>Oct 24, 1956</i> , that I last saw the deceased alive on <i>Oct 24, 1956</i> , and that death occurred at <i>10:15 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>M.D. 1039 St Paul St. Baltimore 2 Md 100518</i>	
ACTUAL SIGNATURE <i>Lester A. Wall Jr.</i>		DATE SIGNED <i>10-29-1956</i>	
PHYSICIAN'S NAME (Type) <i>LESTER A. WALL JR.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-29-1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Torraine Park</i>
22d. LOCATION (City, town, or county) <i>Woodlawn,</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G Howard Strong</i>		24a. REC'D BY REGISTRAR <i>10-29-1956</i>	24b. REGISTRAR'S SIGNATURE <i>Grace MacPhee</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGISTRATION: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DATA

BUREAU Y. S.

OCT 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10083

CERTIFICATE OF DEATH

10065

Reg. Dist. No.

44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 55 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3801-4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 104 North Greene Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First HARRY	Middle P.	Last MULLEN	4. DATE OF DEATH October 13,	Month October	Day 13	Year 19 56		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1895	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months 61	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operating Engineer		10b. KIND OF BUSINESS OR INDUSTRY Civil Service		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Theodore Mullen			14. MOTHER'S MAIDEN NAME Mary Bage						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I			16. SOCIAL SECURITY NO. 577-14-9760		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 543X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH UNKNOWN						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1. Gastritis with hemorrhage 2. Renal Cortical Hemorrhages			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. 19 p. m. VA	Month 19	Day Not while at work <input type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH, FORT HOWARD, MARYLAND	(County)	(State)		
21. I certify that I attended the deceased from August 19, 1956 , to October 13, 1956 , and that death occurred at 6:30A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>C. J. Papastrat MD</i> 10/15/56									
PHYSICIAN'S NAME (Type) C. J. PAPASTRAT, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-17-56	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Blight, Inc.		ADDRESS 6009 Harford Rd., Balto. Md.		24a. REC'D BY REGISTRAR 01161956	24b. REGISTRAR'S SIGNATURE <i>Howard L. Garber</i>				
VS A15 15M 9/55		DATE							

9561 91 130

RECEIVE

BUREAU V. 4

10084 CERTIFICATE OF DEATH

Reg. Dist. No. *30*

INSTRUCTIONS

ATTENDANT'S PHYSICIAN OR HOSPITAL: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Balto. Catonsville 5632 Johnny cake Rd.	MARYLAND LENGTH OF STAY (In this place)	STATE Md. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) Frank		(Month) Oct. (Day) 11 (Year) 56	
(Middle)		(Last) Nardo	
5. SEX M	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Jan. 10, 1893
9. AGE last birthday yrs. 63	10. KIND OF BUSINESS OR INDUSTRY Fruit Produce	11. BIRTHPLACE (State or foreign country) Italy	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Anthony Nardo		14. MOTHER'S MAIDEN NAME Frances Marino	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Mrs. James Biondo 5632 Johnny C. Rd.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>154X IMMEDIATE CAUSE (A) CARCINOMA RECTUM WITH ANTECEDENT CAUSE(S) DUE TO METASTASIS TO LUNGS</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr 2 mos</i>	
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <i>1/23/56</i>	19b. MAJOR FINDINGS OF OPERATION <i>INOPERABLE CARCINOMA RECTUM</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>JAN 1, 1956</i> , to <i>OCT 11, 1956</i> , that I last saw the deceased alive on <i>10/10/56</i> , and that death occurred at <i>1:50 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Raleef A. Nealy</i> M.D. ADDRESS (Street, city, town, state) <i>301 Med. Arts Bldg. Buro. 1</i> DATE SIGNED <i>10/12/56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 10-15-56	NAME OF CEMETERY OR CREMATORIAL Cathedral Cem.	LOCATION (City, town, or county) Balto. Md.
24. REC'D BY REGISTRAR DATE <i>OCT 15 1956</i>	REGISTRAR'S SIGNATURE <i>R. E. Harry</i>	25. FUNERAL DIRECTOR'S SIGNATURE <i>Zapley Funeral Home Catonsville, Md.</i>	ADDRESS

OF THE UNITED STATES TO THE TRADIC STATE ANALYST

STAGE TO STAGEDITION

BUREAU U.S.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10085

CERTIFICATE OF DEATH

10067

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY <i>Baltimore Co</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write rural and give nearest town) <i>Catonsville</i>	c. LENGTH OF STAY IN lb <i>1b</i>	b. COUNTY <i>Baltimore Co</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville 28</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House of Pines</i>	e. STREET ADDRESS <i>2632 Frederick Rd</i>	d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Minnie L</i>	First <i>L</i>	Middle <i>Oale</i>	4. DATE OF DEATH Month <i>10</i> Year <i>1956</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/10/91</i>
9. AGE (In years lost birthday) <i>65 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Day <i>11</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>md.</i>	10c. BIRTHPLACE (State or foreign country) <i>Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>us.</i>
13. FATHER'S NAME <i>Philip Moore</i>	14. MOTHER'S MAIDEN NAME <i>Eliza Grace</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>415-00-0000</i>	17. INFORMANT <i>M. Fleagle</i>	Address <i>100 W. 2nd St., Catonsville, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>155X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
DUE TO <i>(c)</i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>260X Diabetes Insipidus.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>Dec. 31, 1956</i>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19 p. m.</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Howard Co, Md.</i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 31, 1956</i> to <i>10/11/56</i> , that I last saw the deceased alive on <i>10/11/56</i> , and that death occurred at <i>M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Catonsville, Md.</i>			
ACTUAL SIGNATURE <i>S. Lloyd Johnson</i>	DATE SIGNED <i>10/15/56</i>		
PHYSICIAN'S NAME (Type) <i>S. LLOYD JOHNSON, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/15/56</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Howard Shepard</i>	22d. LOCATION (City, town, or county) (State) <i>Howard Co, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Macmillan Caton, 28</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE <i>10/15/56</i>	24b. REGISTRAR'S SIGNATURE <i>T.E. Harry</i>

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10086 CERTIFICATE OF DEATH

10068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Baltimore, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 18yrlmth2ldys		d. STREET ADDRESS 2028 W. Lanvale Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL								
3. NAME OF DECEASED (Type or print) John		First	Middle	Last	4. DATE OF DEATH October 29 1956	Month	Day	Year
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 23, 1870	9. AGE (In years lost birthday) 86 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman		10b. KIND OF BUSINESS OR INDUSTRY —		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure 422.1						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease		DUE TO —						
(c) —		DUE TO —						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —		20f. (City or town) —		(County) — (State) —
21. I certify that I attended the deceased from July 1, 1953 , to October 29, 1956 , that I last saw the deceased alive on Oct. 29, 1956 , and that death occurred at 2:35 P.M. from the causes and on the date stated above.								ADDRESS (Street, city or town, state) —
ACTUAL SIGNATURE Stella Wachsler		M.D.		Spring Grove State Hospital		DATE SIGNED 10-29-56		
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.				Catonsville 28, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11-2-56		22c. NAME OF CEMETERY OR CREMATORIUM MT. OLIVET CEM.		22d. LOCATION (City, town, or county) Baltimore, MD.		(State) —
23. FUNERAL DIRECTOR'S SIGNATURE G. Truman Schuss		ADDRESS 3512 FRED'K RD. N.W.		24a. REC'D BY REGISTRAR 1956		24b. REGISTRAR'S SIGNATURE F. E. Harry		

WISCONSIN STATE GOVERNMENT - BUREAU OF MOTOR VEHICLE
CERTIFICATE OF DEATH

BUREAU V.

JULY 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10069

9977

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper & ages 1 and 2 should be filed with the funeral director.

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE SAME	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK 22		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7990 ST. MONICA DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARGARET	Middle ELIZABETH	Last ORNDUFF
4. DATE OF DEATH	Month OCT.	Day 4	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26, 1885
9. AGE (In years last birthday) yrs. 71		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Hours 0
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME TOBY STARK	
14. MOTHER'S MAIDEN NAME JNK.		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. CHARLES SAWYER - SAME	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH 4 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 447X			
(b) DUE TO Hypertensive Arteriosclerotic Disease Years			
(c) Senility			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured (ununited) hips for 5 years.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Fractured (ununited) hips for 5 years.	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 26, 1956 , to Sept. 13, 1956 that I last saw the deceased alive on 10/7/56 , and that death occurred at 9 AM , from the causes and on the date stated above. ACTUAL SIGNATURE David Owens M.D. ADDRESS (Street, city or town, state) Spurrwood Court 10/7/56 DATE SIGNED 10/7/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-7-56	
22c. NAME OF CEMETERY OR CREMATORIUM KREGER KNOLT		22d. LOCATION (City, town, or county) (State) ABINGDON, VIRGINIA	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Antes, Bradley, Shultz, M.D.		24a. REC'D BY REGISTRAR DATE Oct 8 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE John Kelly	

WISCONSIN STATE GOVERNMENT OF GREENSBORO 18
CERTIFICATE OF DEATH

24116
11/1/65
100

BUREAU V. S.
RECEIVED
OCT 8 1965

10-5-25

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10070
38

10087

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cob Hill</u>	c. LENGTH OF STAY IN lb <u>33 years</u>	b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1003 1 Harford Rd.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cob Hill</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Charles</u>	First <u>m</u>	Middle <u>Pearce</u>	Last <u>OCT 21 1956</u>
4. DATE OF DEATH <u>Oct 21 1956</u>	Month <u>OCT</u>	Day <u>21</u>	Year <u>1956</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 28 1904</u>
9. AGE (In years last birthday) <u>52 yrs.</u>	10. IF UNDER 1 YEAR Months <u>3</u>	11. IF UNDER 24 HRS. Days <u>2</u>	12. IF UNDER 24 HRS. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter Painter</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Painting</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Charles Pearce</u>	14. MOTHER'S MAIDEN NAME <u>Mary HARMAN</u>	Address <u>Edith Pearce 1003 1 Harford Rd.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	16. SOCIAL SECURITY NO. <u>322-12-0001</u>	17. INFORMANT <u>Edith Pearce</u>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intoxication, alcoholic, acute 10 days</u> DUE TO <u>322-12-0001</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Alcoholism Chronic</u> DUE TO (c) <u>Cardiovascular, hypertension, mild</u>
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>5901 Ayleshire Road</u>
20f. (City or town) <u>Baltimore</u>	(County) <u>Md</u>	(State) <u>Md</u>	
21. I certify that I attended the deceased from <u>for about 19 years</u> to <u>19</u> , that I last saw the deceased alive on <u>Oct. 21, 1956</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis N. Rudin</u>	ADDRESS (Street, city or town, state) <u>5901 Ayleshire Road Baltimore 12 Md</u>		
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>10-25-56</u>	22c. NAME OF CEMETERY OR CREMATORIAL <u>Center Presby Terian Church New Park</u>
22d. LOCATION (City, town, or county) <u>New Park</u>		(State) <u>Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Chas F. Evans & Son</u>		24a. REC'D BY REGISTRAR <u>JUL 25 1956</u>	24b. REGISTRAR'S SIGNATURE <u>Dr. D. M. Seeger</u>
ADDRESS <u>8802 Harford Rd</u>		DATE <u>JUL 25 1956</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REGISTRATION FORM 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the registrar.

UNITED STATES GOVERNMENT OF HEALTH-SEALING

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 25 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10071

Reg. Dist. No.

44

10088

CERTIFICATE OF DEATH

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director.
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point		c. LENGTH OF STAY IN 1b 11 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 616 E. St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point	
3. NAME OF DECEASED (Type or print) First Dora Middle M. Peters		4. DATE OF DEATH Last Oct 19, 1956 Month Day Year	
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Feb. 12, 1870
9. AGE (In years lost birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joseph Smith		14. MOTHER'S MAIDEN NAME Mary Little	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Lillian Woodhead		Address 602 E. St. Sparrows Pt.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO <i>443X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Arteriosclerotic CVD</i> DUE TO <i>Senility</i> (c) <i>Rheumatoid Arthritis (severe)</i> INTERVAL BETWEEN ONSET AND DEATH <i>30 min.</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>July 1, 1955, to Oct 19, 1956</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1, 1955, to Oct 19, 1956</i> , that I last saw the deceased alive on <i>Oct. 19, 1956</i> , and that death occurred at <i>238</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>David Owens</i> M.D. <i>914 D St. Baltimore, Md. 10/19/56</i> PHYSICIAN'S NAME (Type) <i>David Owens, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 22, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Oaklawn		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lassahn Funeral Home</i>		ADDRESS 7401 Belair Rd.	
24a. REC'D BY REGISTRAR DATE <i>Oct 22 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Douglas L. Farber</i>	

WISCONSIN STATE DEPARTMENT OF HIGHER EDUCATION

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	DEATH DATE	PLACE OF DEATH
MATERIALS FOR AUTOPSY				
<input type="checkbox"/> Autopsy				
<input type="checkbox"/> Blood				
<input type="checkbox"/> Urine				
<input type="checkbox"/> Sputum				
<input type="checkbox"/> Stool				
<input type="checkbox"/> Tissue				
<input type="checkbox"/> Hair				
<input type="checkbox"/> Bone				
<input type="checkbox"/> Other				
RECEIVED BY				
OCT 22 1956				
BUREAU V. S.				
RECEIVED				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10089

CERTIFICATE OF DEATH

10072

Reg. Dist. No. 37

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson		c. LENGTH OF STAY IN 1b 25 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 02 Mt. Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Mary	Middle Agnes	Last Pierce
4. DATE OF DEATH	Month 10	Day 27	Year 1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/31/92
9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Hospital records	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Allen		14. MOTHER'S MAIDEN NAME Mary Lawless	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Hospital records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Hyper- (b) tension DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 12 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Far Advanced Pulmonary Tuberculosis			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 10/27/56	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/2 , 1956, to 10/27 , 1956, that I last saw the deceased alive on 10/27 , 1956, and that death occurred at 7:40 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) William Newcomer M.D.			
ACTUAL SIGNATURE		DATE SIGNED 10/27/56	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Mt. Wilson, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/31/56	22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Cem.	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home		ADDRESS 130 E. Fort Avenue	
24a. REC'D BY REGISTRAR DATE OCT 30 1956		24b. REGISTRAR'S SIGNATURE Sophy Newell	

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10090

CERTIFICATE OF DEATH

10073

Reg. Dist. No. 44

1. PLACE OF DEATH o. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 21 Days		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		
3. NAME OF DECEASED (Type or print) LEON		First (NMI)	Middle PINDER	
Last MALE		4. DATE OF DEATH October	Month 27	
5. SEX Colored		6. COLOR OR RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 3/6/10	9. AGE (In years lost birthday) 46 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cannery	11. BIRTHPLACE (State or foreign country) Cambridge, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Caleb Pinder		14. MOTHER'S MAIDEN NAME Ella Pinder		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 214 07 8956	17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X		CARCINOMA OF PANCREAS WITH METASTASIS, GENERALIZED		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. { b) DUE TO c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October 6, 1956 , to October 27, 1956 . X I last saw the deceased X and that death occurred at 7:45P M , from the causes and on the date stated above. ACTUAL SIGNATURE Constantine J. Papastrat M.D.		ADDRESS (Street, city or town, state) V.A.H. Fort Howard, Md. DATE SIGNED 10/30/56		
PHYSICIAN'S NAME (Type) CONSTANTINE J. PAPASTRAT, M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-31-56	22c. NAME OF CEMETERY OR CREMATORIUM Chapel Cemetery	22d. LOCATION (City, town, or county) Cambridge, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary, 802-04 Madison Ave. Baltimore, Md.		ADDRESS NOV 2 1956 REG'D BY REGISTRAR DATE REGISTRAR'S SIGNATURE Dawson L. Farber		

Picked up by St. Clair Undertaker, 111 Pine St. Cambridge, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Line 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2, which could be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10091

CERTIFICATE OF DEATH

10074 44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1027 Somerset Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ERNEST	Middle G.	Last POOLE	4. DATE OF DEATH October	Month 8	Day 1956	Year
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 16, 1898	9. AGE (In years last birthday) 58	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. DAYS 0	Yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Cement Work		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jerry Poole		14. MOTHER'S MAIDEN NAME Lucinda Wood		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Clin. Records, Vet. Adm. Hospital, Ft. Howard, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS <i>150x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 1. Pulmonary emphysema 2. Arteriosclerosis, generalized							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that VA attended the deceased from October 4, 1956 , to October 8, 1956 , and that death occurred at 3:50 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Irving Freeman M.D. VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/8/56							
ACTUAL SIGNATURE Irving Freeman							
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-10-56		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law Mortuary Baltimore, Maryland				ADDRESS 802-04 Madison Ave.		24a. REC'D BY REGISTRAR DATE Oct. 25, 1956	
						24b. REGISTRAR'S SIGNATURE Dawson L. Farber	

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BUREAU A. S.

3591 92 1

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10092

10075

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore County 2605 HICKRY AVE. MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
3. NAME OF DECEASED (Type or print) ANNA M. PRZYWARA		First	Middle	
4. DATE OF DEATH	Month	Day	Year	
OCT. 25	1956	19		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Feb. 24 1885	9. AGE (In years lost birthday) 71 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) POLAND	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME J. GALKA		14. MOTHER'S MAIDEN NAME UNK.		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT John Przywara Son	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Acute Cardiac Failure Arterio-Sclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 1/2a 5yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) 679 Washington Blvd. Baltimore 30, Md.
21. I certify that I attended the deceased from 10/25/56, 1956, to 10/25, 1956, that I last saw the deceased alive on 10/25/56, 1956, at death occurred at 7:50 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 679 Washington Blvd. Baltimore 30, Md.		DATE SIGNED 10/26/56
ACTUAL SIGNATURE Joseph G. Laukaitis PHYSICIAN'S NAME (Type)		M.D.		
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 29/56	22c. NAME OF CEMETERY OR CREMATORIAL HOLY ROSARY	22d. LOCATION (City, town, or county) BALTIMORE
23. FUNERAL DIRECTOR'S SIGNATURE FRED W. OZAZIEWSKI		ADDRESS 1930 EASTERN AVE.	24a. REC'D BY REGISTRAR Oct 27 1956	24b. REGISTRAR'S SIGNATURE R. W. DeJohn Jeffers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. GOVERNMENT STATE DEPARTMENT OF HAWAII - BATTALION
CERTIFICATE OF DEATH

NAME

HEADQUARTERS

BUREAU V. S.

OCT 30 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar or removal.

VS. A15ME(5)
5M 9/55

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2
10093

B
10093

38

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10093 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 38	10076		
1. PLACE OF DEATH a. COUNTY Baltimore 500 HICKORY LANE MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE CONN. MARYLAND. BETHEL COUNTY BETHEL, CONN.								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON MD.			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL BETHEL			d. STREET ADDRESS SUNSET HILL ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 500 HICKORY LANE								4. DATE OF DEATH Sept. 28, 1956		Month 10	Day 11	Year 1956	
3. NAME OF DECEASED (Type or print) JOHN F. QUICK.		First	Middle	Last									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH Sept. 28, 1902		9. AGE (In years last birthday) 54 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) VICE PRESIDENT		10b. KIND OF BUSINESS OR INDUSTRY MERCANTILE FOOD DIST.		11. BIRTHPLACE (State or foreign country) New York				12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Nelson Quick					14. MOTHER'S MAIDEN NAME Mary Ann Holmes								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No None					16. SOCIAL SECURITY NO.		17. INFORMANT Family Information		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 9210 DUE TO Asphyxia - Aspiration of Bolus of MEAT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO													
INTERVAL BETWEEN ONSET AND DEATH													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Acute Alcoholism													
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspirated large hunk of meat										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour 9:36 p.m. 10/11 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) 500 Hickory Lane-Balto		(County) MD		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE R. S. Fisher MD		DATE SIGNED 10/12/56											
EXAMINER'S NAME (Type) R. S. FISHER		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15, 1956		22c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery		22d. LOCATION (City, town, or county) Bethel, Conn.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE John Burns Sons, Towson, Maryland		ADDRESS		24a. REC'D BY REGISTRAR DATE 10/12/56		24b. REGISTRAR'S SIGNATURE Mabel C. Gray							
John C. Freeland, Danbury, Conn.													

MISSOURI STATE DEPARTMENT OF HEALTH - FARMERS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10094

CERTIFICATE OF DEATH

10077

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia		b. COUNTY Roanoke	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 68 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Roanoke		d. STREET ADDRESS 1117 Amherst Street S.W.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First STEVE	Middle D.	RAGLAND	4. DATE OF DEATH October 3 1956	Month October	Day 3	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 3, 1915	9. AGE (In years lost birthday) 41	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Telephone Langley Field		11. BIRTHPLACE (State or foreign country) Oxford, Mississippi		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Sam Ragland				14. MOTHER'S MAIDEN NAME Mary E. Wooten			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		16. SOCIAL SECURITY NO. 567-34-2605		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 410 X DUE TO MITRAL VALVULOTOMY				INTERVAL BETWEEN ONSET AND DEATH INSTANTANEOUS			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic Heart Disease, Mitral and Aortic Valves - Duration unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. VA	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from July 27, 1956 , to October 3, 1956 , and that death occurred at 3:20 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Irving Freeman</i>				ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND			
PHYSICIAN'S NAME (Type) IRVING FREEMAN, M.D.				DATE SIGNED 10/4/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10-4-56	22c. NAME OF CEMETERY OR CREMATORIAL Fairview Cemetery	22d. LOCATION (City, town, or county) Roanoke County, Virginia	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook-Bright, Inc.</i>				24a. REC'D BY REGISTRAR OCT 8 1956	24b. REGISTRAR'S SIGNATURE <i>John N. Oakey and Son, Church Ave., Roanoke, Va.</i>		
SHIPPER TO: John N. Oakey and Son, Church Ave., Roanoke, Va.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be recorded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to a burial, cremation, or removal, and in any event within 72 hours after death.

MATERIALS STATE OF HAWAII - BALTIMORE, MD

CERTIFICATE OF DATA

BUREAU V.

OCT 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10078

10095

CERTIFICATE OF DEATH

Reg. Dist. No.

THIS IS A PERMANENT RECORD.
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information she carefully supplied. Physicians: please write the causes of death clearly and legibly.
HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH Oct, 16, th, 1956	
Wm. Valentine Matthew Ratajczak			
3. PLACE OF DEATH A. Baltimore City, Maryland 7213 Conley Street		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION At. Home		A. STATE Maryland	
c. Length of stay in Baltimore 76 yrs		B. COUNTY Baltimore	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	c. CITY OR TOWN Baltimore 24
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 2 Laborer		D. STREET ADDRESS (If rural, give location) 7213 Conley Street	
13. FATHER'S NAME Michael Ratajczak		8. DATE OF BIRTH Feb, 12-1879	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		9. AGE (In years last birthday) 77	
16. SOCIAL SECURITY NO. 212-01-9401		10. KIND OF BUSINESS OR INDUSTRY	
18. 260X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		11. BIRTHPLACE (State or foreign country) Poland	
ANTECEDENT CAUSES		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		14. MOTHER'S MAIDEN NAME Antoinette Sobczak	
ML CERTIFICATION		17. INFORMANT Veronica Stachowiak 7213 Conley Street	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER PART I OR PART II		ADDRESS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
22. I certify that (I) (this hospital) attended the deceased from Oct. 16, 1956, that (I) (we) last saw the deceased alive on and that death occurred at 12 Noon m., from the causes and on the date stated above.		June 19 56 to Oct. 16 19 56	
23A. SIGNATURE ATTENDING PHYS. <i>Benton J. Koch M.D.</i>		23B. ADDRESS STAFF PHYS. <input type="checkbox"/> 2936 E. Balt St	
MED. DIRECTOR <input type="checkbox"/>		23C. DATE SIGNED 10/16/56	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE Oct, 20-1956	
24C. NAME OF CEMETERY OR CREMATORIUM St. Stanislaus Cemetery		24D. LOCATION (City, town, or county) (State) 1300 Dundalk Ave-Balto, Md.	
DATE RECEIVED BY LOCAL REGISTRAR OCT 17 1956 #Washington Avenue		25. FUNERAL DIRECTOR, George R. Weber 7as-8. Ann st	
REGISTRAR'S SIGNATURE		ADDRESS	

CERTIFICATE OF DEATH

1956

Name of deceased: JAMES L. KELLY, JR.
Date of birth: 1912-12-24
Date of death: 1956-10-19NAME TO SIGN
IN BLOCKS

MATERIAL

 LIFE INSURANCE
 MEDICAL INSURANCE
 ACCIDENT INSURANCE
 OTHER INSURANCE

ADDRESS NAME & ADDRESS CITY & STATE		225-104-1187-A		PERMIT NUMBER EXPIRATION DATE			
NAME	AGE	SEX	DEATH DATE	NAME	AGE	SEX	DEATH DATE
JOHN KELLY	43	MALE	1956-10-19	JOHN KELLY	43	MALE	1956-10-19
WIFE	NAME	AGE	DEATH DATE	WIFE	NAME	AGE	DEATH DATE
OTHER INFORMATION							
Address of deceased, date of birth, date of death, cause of death, name of hospital, name of physician, name of funeral home, name of mortician.							
Signature of witness							

NAME		RELATIONSHIP		DATE OF DEATH & PLACE OF DEATH			
JOHN KELLY		HUSBAND		1956-10-19 AT HOME			
WIFE		NAME		DEATH DATE			
WITNESS		NAME		SIGNATURE			
JOHN KELLY		HUSBAND		1956-10-19			
WIFE		NAME		DEATH DATE			

NAME		RELATIONSHIP		DATE OF DEATH & PLACE OF DEATH			
JOHN KELLY		HUSBAND		1956-10-19 AT HOME			
WIFE		NAME		DEATH DATE			
WITNESS		NAME		SIGNATURE			
JOHN KELLY		HUSBAND		1956-10-19			
WIFE		NAME		DEATH DATE			

RECEIVED BY

OCT 19 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10096

CERTIFICATE OF DEATH

10079 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 323, Old North Point Rd.		d. STREET ADDRESS Box 323, Old North Point Rd.				
3. NAME OF DECEASED (Type or print)	First Sebastian	Middle	Last Rauh			
4. DATE OF DEATH October 1 1956	Month	Day	Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25, 1881			
9. AGE (In years last birthday) 75 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Steel Worker	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland			
13. FATHER'S NAME George Rauh		14. MOTHER'S MAIDEN NAME Augustina Boehner				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-07-9185	17. INFORMANT George Rauh Address 1915 Ellenwood Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 154X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 11 mos.				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County)	(State)
21. I certify that I attended the deceased from Dec 1956 to Oct 1 1956, that I last saw the deceased alive on Apr 30 1956, and that death occurred at 2:20 P.M. from the causes and on the date stated above.						
ACTUAL SIGNATURE M.B. Davis	M.D.		ADDRESS (Street, city or town, state) 6800 MORNIN' MOTION LANE 107/117 Bundek - 22 Md			
DATE/SIGNED 10/11/56						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 4, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart	22d. LOCATION (City, town, or county) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc., 403 S. Wolfe Street		ADDRESS	24a. REC'D BY REGISTRAR DATE Oct. 8 1956	24b. REGISTRAR'S SIGNATURE Hawson L. Farley		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

OCT 3 1956

BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10097

CERTIFICATE OF DEATH

10080

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 303 Reisterstown Rd.		d. STREET ADDRESS 303 Reisterstown Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle HARRY	Last REISINGER	4. DATE OF DEATH Oct. 2, 1956	Month Oct.	Day 2	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1885	9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rtd. Office Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frederick P. Reisinger		14. MOTHER'S MAIDEN NAME Julia Dietrich					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 705-10-5575		17. INFORMANT Mrs. G. Hartman Blumberg - 216 Chancery Rd.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 3 hours.			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO Coronary Sclerosis		2 yrs			
		(c) Art. Sclerosis		5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan.</u> , 1954, to <u>Oct 2</u> , 1956, that I last saw the deceased alive on <u>Oct. 2</u> , 1956, and that death occurred at <u>2:30</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE <i>James A. Miller Jr.</i>		M.D.		DATE SIGNED 10/3/56			
PHYSICIAN'S NAME (Type) <i>Dr. James A. Miller</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/56		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cem.		22d. LOCATION (City, town, or county) Pikesville, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Am. J. Schaefer & Sons - Balto. 17. Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE Oct. 3, 1956		24b. REGISTRAR'S SIGNATURE <i>Dorothy Renfry</i>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10098

CERTIFICATE OF DEATH

10081

Reg. Dist. No.

or
1/4

THIS IS A PERMANENT RECORD.
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information must be carefully supplied. Physicians: please write the causes of death clearly and legible.

M.L. CERTIFICATION

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Phillip P. Rice.		October 2, 1956	
3. PLACE OF DEATH: A. Baltimore City, Maryland		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
B. FULL NAME OF HOSPITAL OR INSTITUTION 52 Catonsville		A. STATE Maryland	B. COUNTY
INSTITUTION Shady Nook Nursing Home.		C. CITY OR TOWN Baltimore	(If outside corporate limits, write RURAL and give township) 3801-4
c. LENGTH OF STAY IN BALTIMORE Life		D. STREET ADDRESS (If rural, give location) 4003 Hickory Ave.	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widower.	8. DATE OF BIRTH October 8/1909
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Traffic		10B. KIND OF BUSINESS OR INDUSTRY McCormick & Co.	9. AGE (in years last birthday) 46
13. FATHER'S NAME William Rice.		11. BIRTHPLACE (State or foreign country) Maryland.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		12. CITIZEN OF WHAT COUNTRY? U.S.	
		16. SOCIAL SECURITY NO. 213 10 8187	17. INFORMANT Mrs. Vivian Cage, 4003 Hickory Ave.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 17X ANTECEDENT CAUSES		CAUSE OF DEATH Broncho Pneumonia DUE TO Paroxysmal Taxis DUE TO Primary tumor Prostate DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		INTERVAL BETWEEN ONSET AND DEATH 3 Days. 4 years. 4 years.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II 21D. TIME (MONTH) (YEAR) (YEAR) (MONTH) OF INJURY		19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 21E. INJURY OCCURRED m. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?	
		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug 21</u> to <u>Oct 1</u> , 1956, that (I) (we) last saw the deceased alive on <u>Oct 1</u> , 1956, and that death occurred at <u>11:10 A.M.</u> m., from the causes and on the date stated above.			
23A. SIGNATURE Wortham Fort- ATTENDING PHYS. <input type="checkbox"/>		23B. ADDRESS 1118 St. Paul St.- M.D. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		23C. DATE SIGNED 10/3/56-	
24B. DATE Oct 5, 1956		24C. NAME OF CEMETERY OR CREMATORIAL Lorraine Park.	
DATE RECEIVED BY LOCAL REGISTRAR		24D. LOCATION (City, town, or county) (State) Windsor Mill Rd, Md.	
REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR Tuerlin E. Donovan-3818 Poland ADDRESS	

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1981 EDITION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10082

10099 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN lb 50 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3 V O I - L	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4106 Edmondson Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First FRED	Middle (NMI)	Last ROWAN	4. DATE OF DEATH October	Month 6	Day 19	Year 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 7/9/88	9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 68	IF UNDER 24 HRS. Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Storeroom Keeper		10b. KIND OF BUSINESS OR INDUSTRY Electric Co.		11. BIRTHPLACE (State or foreign country) Iowa		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John W. Rowan		14. MOTHER'S MAIDEN NAME Mary McNamara					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 361-03-9236		17. INFORMANT Clin. Rec. Vets. Admin. Hospital, Ft. Howard, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X		CARCINOMA PANCREAS WITH MEDIASTINAL, HEPATIC DUE TO BONE METASTASIS				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) SUPERIOR VENA CAVA OBSTRUCTION						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Maryland
21. I certify that I attended the deceased from August 17, 1956 , to October 6, 1956 . and that death occurred at 4:00 A.M. , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>Walter J. Pijanowski</i>	M.D. Veterans Administration Hospital						10/6/56
PHYSICIAN'S NAME (Type) WALTER J. PIJANOWSKI, M. D.	FORT HOWARD, Md.						
22o. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-10-56	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National	22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE, <i>J. Cook-Bright Inc.</i>		ADDRESS 1009 Harford Rd., Balt., Md.	24a. REC'D BY REGISTRAR DATE 10 10 56		24b. REGISTRAR'S SIGNATURE <i>Dawson L. Farless</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 and Part 2 may be retained by the hospital or attending physician. Part 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Part 1 and Part 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
OCT 10 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10100

CERTIFICATE OF DEATH

10083

Reg. Dist. No. 3

1. PLACE OF DEATH a. COUNTY 16 Fusting Ave.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b Life	b. COUNTY				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				
d. STREET ADDRESS 6107 Regent Park Road		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Marion	Middle Vincent	Last Russell			
4. DATE OF DEATH Oct.	Month 25	Day 19	Year 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 26, 1874	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel Mgr.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S. A.
13. FATHER'S NAME William Russell			14. MOTHER'S MAIDEN NAME Roseanna Patterson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT William T. Russell 6107 Regent Park Road, Balto. Md.		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardio-vascular renal disease 442X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Acute Uremia DUE TO (c) DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
INTERVAL BETWEEN ONSET AND DEATH						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan. 11, 1952, to October 25, 1956, that I last saw the deceased alive on October 25, 1956, and that death occurred at 1:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE George A. Knipp, M. D. PHYSICIAN'S NAME (Type)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 27, 1956		22c. NAME OF CEMETERY OR CREMATORIUM New Cathedral Cem.		22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Henry W. Jenkins & Sons Co., Inc.		ADDRESS 4905 York Road Balto. 12, Md.		24a. REC'D BY REGISTRAR DATE Oct. 30 1956		24b. REGISTRAR'S SIGNATURE J. E. Harry

DEPARTMENT OF HEALTH - SANITATION

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 30 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10101

CERTIFICATE OF DEATH

10084 *ff*

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
Baltimore MARYLAND		Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Overlea		Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
209 Leslie Ave.	209 Leslie Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Herman	Middle Schmidt	4. DATE OF DEATH
5. SEX m	6. COLOR OR RACE w	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
			9. AGE (in years lost birthday) yrs. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cobbler	Shoe Repair	Germany	U.S.A.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Herman R. Schmidt	Unknown Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	218-14-9866	Mrs. Pauline H. Schmidt	209 Leslie Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	20 min		
420.1 Pulmonary Edema			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.	30 min		
(b) Ventricular fibrillation			
DUE TO	2 hrs		
(c) Myocardial Infarction			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
Hyper tension Cardiac vascular Disease 30 yrs stand			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10 am 10-29, 1956, to 11 pm 10-29, 1956, that I last saw the deceased alive on 11 am 10-29, 1956, and that death occurred at 11:55 pm M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE John C. H. H.	DATE SIGNED		
PHYSICIAN'S NAME (Type)	M.D. 7527 Belair Rd. Baltimore, Md. 10-30-56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 2, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home	ADDRESS 7401 Belair Rd.	24a. REC'D BY REGISTRAR NOV - 1 1956	24b. REGISTRAR'S SIGNATURE Mrs. L. L. Lassahn

BUREAU V. S.

NOV 1 1956

REFUGIUM FEL

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10085

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home-301 Chesapeake Ave.		e. STREET ADDRESS 108 Wyndhurst Ave.		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle AMELIA	Last SCOTT	4. DATE OF DEATH Oct. 3, 1956	Month Oct.	Day 3,	Year 1956
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1880	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months 75	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wm. P. Backmiller		14. MOTHER'S MAIDEN NAME Mary Amelia Wasmus					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Harry Scott - 108 Wyndhurst Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Due To Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due To (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 10 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, to _____, that I last saw the deceased alive on _____, and that death occurred at _____ M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>A. Allan Spier</i>	M.D. 4108 Loch Raven Blvd						
PHYSICIAN'S NAME (Type) <i>A. ALLAN SPIER</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/6/56		22c. NAME OF CEMETERY OR CREMATORIUM Friends Burial Ground		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. J. Schneiders & Sons - Balt. 17 Md. 18</i>	ADDRESS <i>10085</i>		24a. REC'D BY REGISTRAR DATE <i>10/6/56</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BUREAU V.

1956 8-19

REFUGEE FED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, Item 4 Film G205 10-10-56 et
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Item 1 and 2 should be filed with

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1810085

Item 4 Film G205 10-10-56 et

10103

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's Co. ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Catonsville		c. LENGTH OF STAY IN 1b 7mths 3dys			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tall Timbers, Maryland			
3. NAME OF DECEASED (Type or print) Alexander I.		d. STREET ADDRESS Tall Timbers, Md.			
4. DATE OF DEATH October 2, 1956	5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH unknown	9. AGE (In years less birthday) 74 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant	11. KIND OF BUSINESS OR INDUSTRY Store	12. BIRTHPLACE (State or foreign country) Maryland	13. CITIZEN OF WHAT COUNTRY? U. S. A.
14. FATHER'S NAME John Sheehan		15. MOTHER'S MAIDEN NAME Ellen J. Bean		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4221 Conditions, if any, which gave rise to immediate cause (o), stating the under- lying cause lost. (b) DUE TO				INTERVAL BETWEEN ONSET AND DEATH	
(c) DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 29, 1956, to Oct. 2, 1956, that I last saw the deceased alive on Oct. 2, 1956, and that death occurred at 11:20 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED 10-3-56	
ACTUAL SIGNATURE Stella Wachsler		M.D.		SPRING GROVE STATE HOSPITAL	
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville e 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/6/56		22c. NAME OF CEMETERY OR CREMATORIUM St. Georges	
23. FUNERAL DIRECTOR'S SIGNATURE Robinson Funeral Home Leonardtown		ADDRESS		24a. REC'D BY REGISTRAR Valley Lee, Md.	
				24b. REGISTRAR'S SIGNATURE Glenn R. Hauser J. E. Harry D.	
				DATE 10/5/56	

BUREAU V.

1956 8 T

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10087

10104

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1421 Glendale Road		d. STREET ADDRESS 1421 Glendale Road	
3. NAME OF DECEASED (Type or print) Otho Thomas Shepherd		4. DATE OF DEATH October 22, 1956	Month Year Day Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 9, 1869
8. AGE (In years lost birthday) 87	9. IF UNDER 1 YEAR Months 0	10. IF UNDER 24 HRS. Days 0	11. IF UNDER 24 HRS. Hours 0
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME W. Shepherd		14. MOTHER'S MAIDEN NAME Helen Domer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Phoebe J. Shannon		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Renal - Vascular Disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH 1/2 yr	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Oct. 20 1956	
20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 20 , 19 56 , to Oct. 22 , 19 56 , that I last saw the deceased alive on Oct. 22 , 19 56 , and that death occurred at 5:30 P.M. , from the causes and on the date stated above. ACTUAL SIGNATURE George E. Shannon PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/56	
22c. NAME OF CEMETERY OR CREMATORIUM Elmwood Cemetery		22d. LOCATION (City, town, or county) Shepherdstown, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Bast Funeral Home, Boonsboro, Maryland		24a. REC'D BY REGISTRAR DATE 10/26/56	
ADDRESS Boonsboro, Maryland		24b. REGISTRAR'S SIGNATURE Mrs. A. L. Bynum	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Form 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Form 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Date of Birth

Name of Deceased

Cause of Death

Place of Death

Name
of
DeceasedDate of Birth
and
Death

BUREAU N.Y.

OCT 29 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death. After this copy has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10088

10105 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		MARYLAND		STATE N.Y.		COUNTY	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN COCKEYSVILLE		LENGTH OF STAY (in this place) 19 MONTHS		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN GREEN		(If rural give location) STREET ADDRESS INDIAN BROOK RD	
HOSPITAL OR INSTITUTION OR STREET ADDRESS MASONIC HOME							
3. NAME OF DECEASED (First) CATHERINE E (Middle) SIBLEY (Last)				4. DATE OF DEATH OCT 18 '56			
5. SEX F	6. COLOR OR RACE 111	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH 9/18/1862	9. AGE last birthday 94 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S
13. FATHER'S NAME MICHAEL THORNE				14. MOTHER'S MAIDEN NAME ISABEL L. SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS Frank L. Smith Jr Cockeysville, Md			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) Arterio-Sclerotic Cardio Vascular disease 15 months ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 3/6, 1955, to 10/17, 1956, that I last saw the deceased alive on 10/17, 1956, and that death occurred at 12:10 A.M., from the causes and on the date stated above. SIGNATURE Walter J. Kees M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 10/20/56		NAME OF CEMETERY OR CREMATORIAL Lorraine		ADDRESS (Street, city, town, state) Cockeysville, Md.	
24. REC'D BY REGISTRAR DATE Oct. 18, 1956		REGISTRAR'S SIGNATURE Frank Smith		25. FUNERAL DIRECTOR'S SIGNATURE Tom Cook Inc. 1217 St Paul St		ADDRESS	

WISCONSIN STATE BOARDMENT OF NATURAL RESOURCES

DEPARTMENT OF DEATH

44-120

NAME AND ADDRESS OF THE DECEASED

DEATH CERTIFICATE

NAME

NAME

NAME

NAME

BUREAU V.

OCT 19 1956

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10106

CERTIFICATE OF DEATH

10089
Reg. Dist. No.

38

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 701 W. Joppa Rd.		d. STREET ADDRESS 701 W. Joppa Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)	First A.	Middle CLARENCE	Last SMINK	4. DATE OF DEATH Oct. 31 1956
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 17, 1875	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Year Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Hebbville, Maryland	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown	Address
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. None	17. INFORMANT Rose Talley Smink, 701 W. Joppa Rd.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>	5 hrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)	Cerebral hemorrhage		
DUE TO (c)	Hypertensive cardiovascular disease		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 10/31 , 19 55 , to 10/31 , 19 56 , that I last saw the deceased alive on 10/31 , 19 56 , and that death occurred at 10 P.M. , from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE <i>Dr. Thomas G. Abbott</i>	M.D.	Oct. 31, 1956
PHYSICIAN'S NAME (Type) Thomas G. Abbott, M.D.	4509 Liberty Heights Ave. - Balto., Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/3/1956	22c. NAME OF CEMETERY OR CREMATORIUM Woodlawn Cemetery	22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth Armacost</i>	ADDRESS Ellsworth Armacost - 4600 Liberty Heights Ave.	24a. REC'D BY REGISTRAR 15 1956	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>
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DEPARTMENT OF GOVERNMENT - BALTIMORE - 10

CERTIFICATE OF DEATH

BUREAU V. S.

NOV 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Fill in below the funeral director's name and address. This certificate is good for 3 days from the date of issue.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

.10107

CERTIFICATE OF DEATH

10090

Reg. Dist. No. 38

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Jowson		c. LENGTH OF STAY IN lb c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1804 Aberdeen Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JOHN	Middle WILLIAM	Last SNYDER, SR.
4. DATE OF DEATH	Month 10	Day 12	Year 19 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/16/1879
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Pinkerton Detective Agency	11. BIRTHPLACE (State or foreign country) Balto. Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John W. Snyder	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. Yes		17. INFORMANT Mr. John W. Snyder-1804 Aberdeen Road #4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hernia		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 442X		(b) Cardio-vascular renal disease	
DUE TO (c) Hemiplegia			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) General arterio-sclerosis - hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month Oct	Day 27	Year 19 56
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 8155 Loch Raven Blvd.		20f. (City or town) Baltimore
(County) Baltimore		(State) Maryland	
21. I certify that I attended the deceased from Oct 12, 1956 to Oct 12, 1956 that I last saw the deceased alive on Oct 12, 1956 , and that death occurred at 8 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 8155 Loch Raven Blvd.			
ACTUAL SIGNATURE Dr. Lee K Farco	DATE SIGNED Lee K Farco		
PHYSICIAN'S NAME (Type) DR LEE K FARCO			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/16/56	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Carson & Sons - Mort. & Pa. Grace	ADDRESS Baltimore, Md.	24a. REC'D BY REGISTRAR DATE OCT 19 1956	24b. REGISTRAR'S SIGNATURE Mabel Gray

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED	AGE	SEX	CAUSE OF DEATH
WILLIAM H. COOPER	60	M	CHLOROFORM OVERDOSE
ADDRESS	STREET	CITY	STATE
101 E. BELMONT	ST. LOUIS	MO.	U.S.A.
RELATIONSHIP	DEATH CERTIFICATE NO.	ISSUED BY	DATE ISSUED
SON	101-5000	MD. DEPT. OF HEALTH	OCT 15 1956
RECEIVED			
BUREAU Y			

OCT 15 1956

RECEIVED

18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10108 CERTIFICATE OF DEATH

10091

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland.		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 2 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2205 Old Frederick Rd.		d. STREET ADDRESS 2205 Old Frederick Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First Bertha	Middle Springer	Last Oct.	DATE OF DEATH 16,	Month 19	Day 56
S. SEX F.	6. COLOR OR RACE W.	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1889	9. AGE (In years lost birthday) 67	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 16	Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY O.H.		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William I. Beswell		14. MOTHER'S MAIDEN NAME Nancy Riley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Eugene R. Springer, 2205 Old Frederick Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis						INTERVAL BETWEEN ONSET AND DEATH 6 yrs.	
332X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b) Cerebral Atherosclerosis					15 yrs
		DUE TO (c) Hypertension - Essential					18 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arterioscler & Hypertensive Heart Disease - Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	(County) (State) Md.
19							
21. I certify that I attended the deceased from January , 19 57 , to Oct. 16 , 19 56 , that I last saw the deceased alive on Our 15 , 19 56 , and that death occurred at 5-10 M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 4111 Liberty Heights Ave		DATE SIGNED 10/16/56	
ACTUAL SIGNATURE Albert J. Shockat		M.D.					
PHYSICIAN'S NAME (Type) Albert J. Shockat M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 19/56		22c. NAME OF CEMETERY OR CREMATORIUM Moreland Mem. Park		22d. LOCATION (City, town, or county) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harry A. Witzke		ADDRESS 101 Edmondson Ave		24a. REG'D BY REGISTRAR Oct 18 1956		24b. REGISTRAR'S SIGNATURE J. E. Harry	

RECEIVED STATE DEPARTMENT OF HEALTH - BALTIMORE 10
NOV 10 1956

CERTIFICATE OF DEATH

DEATH CERTIFICATE

BUREAU V. S.

OCT 18 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10109

CERTIFICATE OF DEATH

10092
44

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 lines 1 & 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Lines 1 and 3 could be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY BALTO.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT		c. LENGTH OF STAY IN lb 40 lbs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SPARROWS POINT				
d. NAME OF HOSPITAL (If not in hospital, give street address) 510 D ST.				d. STREET ADDRESS 510 D ST.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) WALTER		First	Middle	Last	4. DATE OF DEATH 10-15-	Month	Day	Year 1956
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH OCT. 28, 1874	8. AGE (In years at birthday) 81 yrs.	9. IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MOULDER				10b. KIND OF BUSINESS OR INDUSTRY STEEL MFGR.	11. BIRTHPLACE (State or foreign country) PENNA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME AUGUST		14. MOTHER'S MAIDEN NAME STEVENSON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-09-25887.		17. INFORMANT Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO <i>Hypostatic Pneumonia</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Thrombosis</i> ONSET AND DEATH 1/2 yrs.								
DUE TO (c) <i>Atherosclerosis of brain</i> 4 yrs								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) BALTO.	(County)	(State)		
21. I certify that I attended the deceased from <u>June</u> , 1952, to <u>Oct. 15</u> , 1956, that I last saw the deceased alive on <u>Oct. 15</u> , 1956, and that death occurred at <u>520 D St. Balt. 19</u> , M, from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>J. T. Means</i>		ADDRESS (Street, city or town, state) <i>520 D St. Balt. 19</i> DATE SIGNED <i>10/18/56</i>						
PHYSICIAN'S NAME (Type) <i>J. T. Means</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) BALTO		22b. DATE THEREOF 10-18-56	22c. NAME OF CEMETERY OR CREMATORIUM OAK BROWN		22d. LOCATION (City, town, or county) BALTO, CO., MD			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Brooks Bentley, Renwick, Md.</i>		ADDRESS <i>Walter Brooks Bentley, Renwick, Md.</i>	24a. REC'D BY REGISTRAR DATE Oct 18 1956		24b. REGISTRAR'S SIGNATURE <i>Lawson L. Farley</i>			

CERTIFICATE OF DEATH

BUREAU V.

OCT 18 1956

REGD V E D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10093

Reg. Dist. No.

43

10110

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea		c. LENGTH OF STAY IN 1b Overlea	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Willow Ave.		d. STREET ADDRESS 5 Willow Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Laura R. Steward	First	Middle	Lost
4. DATE OF DEATH October	Month	Day	Year 30, 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 31, 1885
9. AGE (In years last birthday) 70 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At Home	
10c. BIRTHPLACE (State or foreign country) Westminster, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James C. Mobley		14. MOTHER'S MAIDEN NAME Myra Lykens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Charles W. Steward		Address 5 Willow Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 175x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. Metastatic Carcinoma Primary Ovarian			
INTERVAL BETWEEN ONSET AND DEATH 2 2 2			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 1, 1956, to Oct. 30, 1956, that I last saw the deceased alive on Oct. 19, 1956, and that death occurred at 5:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Arthur J. Gundlach</i> PHYSICIAN'S NAME (Type) <i>M. J. Grossfeld M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 1, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Mount Olive
22d. LOCATION (City, town, or county) Randallstown, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		24a. REC'D BY REGISTRAR DATE NOV - 1 1956	24b. REGISTRAR'S SIGNATURE Mrs. A. L. Pfeifer

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NOV 1 1956

REGELIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

10094
Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2 yrs. 4 mos.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
						d. STREET ADDRESS 703 Hillen Road			
3. NAME OF DECEASED (Type or print) Susanna		First	Middle	Last	4. DATE OF DEATH October 25,	Month	Day	Year	1956
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Dec. 23, 1871	9. AGE (In years last birthday) 84	IF UNDER 1 YEAR Months 84	IF UNDER 24 HRS. Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dress Maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME William Henry Swam		14. MOTHER'S MAIDEN NAME Clara Jane Painter							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Bertha N. Swam		Address Baltimore 17 151 W. Lafayette Avenue			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hypostatic Pneumonia		DUE TO 422.1		INTERVAL BETWEEN ONSET AND DEATH 5 days					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Epilepsy		DUE TO (b)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic Cardio Vascular Disease		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Sept 21, 1954 to Oct. 25, 1956							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 6419 Windsor Mill Road		(County)	(State)
21. I certify that I attended the deceased from on Oct. 24, 1956 , and that death occurred at 9 A. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Baltimore 7 Maryland							
ACTUAL SIGNATURE Joshua H. Armacost		DATE SIGNED M.D.							
PHYSICIAN'S NAME (Type) Joshua H. Armacost									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 27, 1956		22c. NAME OF CEMETERY OR CREMATORIAL St. Mary's (Hampden)		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Burgee Funeral Home		ADDRESS 3631 Falls Road							
		24a. REC'D BY REGISTRAR Oct. 29, 1956							
		24b. REGISTRAR'S SIGNATURE J. E. Harry							

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• **10.1007/s00332-010-9000-0** DOI 10.1007/s00332-010-9000-0

SUREAU V. S.

OCT 30 1956

REFUGIUM

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10112 CERTIFICATE OF DEATH

10095

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 37 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 2702 Pelham Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Also: ROBERT ^{1st} (Type or print) LOUIS		Middle R. SWEITZER)		4. DATE OF DEATH October 4 1956		Month Day Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH August 10, 1895	9. AGE (In years lost birthday) 61	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Year Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman - city- retired		10b. KIND OF BUSINESS OR INDUSTRY Fire Department		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Sweitzer		14. MOTHER'S MAIDEN NAME Rose Siefort					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		16. SOCIAL SECURITY NO. 217-26-6817		17. INFORMANT Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE		DUE TO RHEUMATIC HEART DISEASE WITH AORTIC STENOSIS				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 411X		(b) DUE TO 				UNKNOWN	
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. VAH, FORT HOWARD, MARYLAND		20f. (City or town) (County) Baltimore (State) MARYLAND	
21. I certify that I attended the deceased from August 28, 1956 , to October 4, 1956 , and saw the deceased alive, and that death occurred at 11:50A M , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED 10/4/56	
ACTUAL SIGNATURE <i>James H. Nolan</i>							
PHYSICIAN'S NAME (Type) JAMES H. NOLAN, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-56		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ullrich Funeral Home</i>		ADDRESS		24a. REC'D. BY REGISTRAR 110 1956		24b. REGISTRAR'S SIGNATURE <i>Lawson L. Farber</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10113

CERTIFICATE OF DEATH

10096

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Catonsville		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Caton Ridge Nursing Home-329 Harlem		Lane		d. STREET ADDRESS 1825 E. 31st St.	
3. NAME OF DECEASED (Type or print)		First MARGARET	Middle TALL	4. DATE OF DEATH Month Oct.	Day 11, Year 1956
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1866	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife (rta)		10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John H. Riehl		14. MOTHER'S MAIDEN NAME Catherine H. --			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Mr. J. H. Riehl, Jr.-4439 Wickford Rd.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		arterio sclerotic heart disease Generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH years yes	
(b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 1101 N Calvert St, Balt. 2	(County) (State) 10/13/56
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Ernest C. Brown M.D. 1101 N Calvert St, Balt. 2 10/13/56	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)	Ernest C. Brown		DATE SIGNED 10/13/56		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/13/56	22c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cem.	22d. LOCATION (City, town, or county) Pikesville, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Hann J. Lickner & Sons - Balt. 17 Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 10/13/56	24b. REGISTRAR'S SIGNATURE D. E. Sanyo		

CERTIFICATE OF DATA

1013

BUREAU V. S.

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 FilmG205 10-29-56 et

10114

CERTIFICATE OF DEATH

10097

Reg. Dist. No. 45

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		c. LENGTH OF STAY IN 1b <i>54 Middle River</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. IS RESIDENCE ON A FARM? / YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>[Redacted] EMMA</i>		First <i>[Redacted]</i>	Middle <i>VA.</i>			
4. DATE OF DEATH Month <i>October 20,</i>	Day <i>19</i>	Year <i>56</i>				
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 21, 1890</i>			
9. AGE (In years last birthday) <i>66 yrs.</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House-keeper</i>		11. KIND OF BUSINESS OR INDUSTRY <i>Can-Home</i>			
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. BIRTHPLACE (State or foreign country) <i>Balto.</i>				
14. FATHER'S NAME <i>John Mengel</i>		15. MOTHER'S MAIDEN NAME <i>Carrie Smith</i>				
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		17. SOCIAL SECURITY NO. <i></i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>				
(b) DUE TO <i>Coronary Sclerosis</i>		10 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i></i>	(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>April 19, 1946</i> , to <i>Oct 20, 1956</i> , that I last saw the deceased alive on <i>Oct 20, 1956</i> , and that death occurred at <i>7:30 P.M.</i> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>A. Kolodny MD</i>		ADDRESS (Street, city or town, state) <i>1225 Bayless Ave Balt. 21, Md.</i>		DATE SIGNED <i>10/20/56</i>		
PHYSICIAN'S NAME (Type) <i></i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-24-56</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>London Pl.</i>	22d. LOCATION (City, town, or county) <i>Balto.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Connelly, Esq. Md.</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR <i>OCT 24 1956</i>	24b. REGISTRAR'S SIGNATURE <i>Edith Hurley</i>	

BUREAU V. S.

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10115

CERTIFICATE OF DEATH

10098
38

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>15 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>1218 Boyce ave</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1218 Boyce ave</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>JULIA</i>		First	Middle	Last	4. DATE OF DEATH <i>MAY 14 1956</i>	Month	Day	Year
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 25, 1876</i>		9. AGE (In years last birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Warren, Balto Co.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
13. FATHER'S NAME <i>John H Taylor</i>		14. MOTHER'S MAIDEN NAME <i>Sassie E. Green</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Mrs Spilker - same</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary artery occlusion</i>		DUE TO (b) <i>Arteriosclerotic cardiovascular disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>10 min</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i>		DUE TO (c)						
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>17 W. PENNA. AVE. TOWSON 4 Md</i>		20f. (City or town) <i>TOWSON</i>		(County) <i>Montgomery</i> (State) <i>Md.</i>
21. I certify that I attended the deceased from <i>JULY 12, 1956</i> , to <i>OCT 14, 1956</i> , that I last saw the deceased alive on <i>OCT 11, 1956</i> , and that death occurred at <i>2:35 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>THADDEUS C. SWIANSKI</i> PHYSICIAN'S NAME (Type) <i>THADDEUS C. SWIANSKI</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 17, 1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Poplar Grove Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore County, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry W. Jenkins Sons Co</i>		ADDRESS <i>4905 York Road</i>		24a. REC'D BY REGISTRAR <i>Oct 17, 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to removal, cremation, or burial, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MILITARY STATE DEPARTMENT OF HEALTH-ARMED FORCES

CERTIFICATE OF DEATH

RECEIVED	SEARCHED	INDEXED	SERIALIZED	FILED
OCT 18 1956				
BUREAU V. S.				
RECEIVED				

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10116

CERTIFICATE OF DEATH

10099-44

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Box 1 and 3 could be filed with registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1007 Sharp Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AARON		First	Middle	Last	4. DATE OF DEATH October 9 1956	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/3/90		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Gas & Electric Co		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Aaron Thomas					14. MOTHER'S MAIDEN NAME Cassie (Maiden name unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> WWI					16. SOCIAL SECURITY NO. 212-05-5122 17. INFORMANT Clin Rec. Vets. Admin. Hospital, Ft. Howard, Md. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF PROSTATE WITH GENERALIZED METASTASIS					INTERVAL BETWEEN ONSET AND DEATH UNKNOWN				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour o. p.m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from October 2, 1956, to October 9, 1956, that I last saw the deceased alive on October 2, 1956, and that death occurred at 1:05 PM, from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) VAH, FORT HOWARD, MARYLAND DATE SIGNED 10/10/56									
ACTUAL SIGNATURE <i>Donald D. Mark</i>		M.D.							
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/12/56		22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National		22d. LOCATION (City, town, or county) Baltimore, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. Lyle</i>		ADDRESS 1022 Madison Ave., Baltimore, Maryland		24a. REC'D'D BY REGISTRAR 011151956		24b. REGISTRAR'S SIGNATURE <i>Donald L. Lyle</i>			

WISCONSIN STATE GOVERNMENT - BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 15 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10117

CERTIFICATE OF DEATH

10160 44
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 77 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1821 Rayner Avenue		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ELLIS		First	Middle	Last	4. DATE OF DEATH THOMAS	Month October	Day 2	Year 1956
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 24, 1895	9. AGE (In years last birthday) 61	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Prince Edward Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes		16. SOCIAL SECURITY NO. 213-07-1093		17. INFORMANT Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LEFT MAXILLARY SINUS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 160X (b) LOBULAR PNEUMONIA DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN				
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, Fort Howard, Maryland		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from July 17, 1956 to October 2, 1956 , and saw the deceased die on October 19, 1956 , and that death occurred at 5:40 PM , from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>R. G. Maels</i>		ADDRESS (Street, city or town, state) M.D. VAH, FORT HOWARD, MARYLAND						
PHYSICIAN'S NAME (Type) DONALD D. MARK, M.D.		DATE SIGNED 10/3/56						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-8-56		22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Lloyd O. Wilson</i>		ADDRESS 1000 Brantley Ave., Balto., Md.						
		24a. REC'D BY REGISTRAR OCT 5 1956						
		24b. REGISTRAR'S SIGNATURE <i>Donald L. Farber</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the funeral director. Forms 1 and 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Forms 1 and 3 register prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED	
MORTON LEE COOPER	
BORN JUNE 10, 1925 DECEASED NOVEMBER 1, 1956	
ADDRESS	
100 E. 10TH ST. NEW YORK CITY	
CITY AND STATE	
NEW YORK CITY NEW YORK	
AGE AT DEATH	
61	
CAUSE OF DEATH	
HEART DISEASE	
TIME OF DEATH	
NOON	
PLACE OF DEATH	
HOME	
TIME OF OCCURRENCE	
NOON	
NAME OF DOCTOR	
DR. RICHARD H. COOPER	
ADDRESS OF DOCTOR	
100 E. 10TH ST. NEW YORK CITY	
NAME OF FUNERAL DIRECTOR	
HAROLD S. COOPER	
ADDRESS OF FUNERAL DIRECTOR	
100 E. 10TH ST. NEW YORK CITY	
NAME OF CEMETERY	
NEW YORK CITY CEMETERY	
ADDRESS OF CEMETERY	
100 E. 10TH ST. NEW YORK CITY	
TIME OF BURIAL	
NOON	
NAME OF PERSON SIGNING	
MORTON LEE COOPER	
SIGNATURE	
MORTON LEE COOPER	
DATE	
NOVEMBER 1, 1956	
TIME	
NOON	
WITNESS	
DR. RICHARD H. COOPER	
SIGNATURE	
DR. RICHARD H. COOPER	
DATE	
NOVEMBER 1, 1956	
TIME	
NOON	

FBI BUREAU

OCT 5 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files. **FOR FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10101 *30
282*
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 18 yrs 10 moth		a. STATE Maryland b. COUNTY St. Mary's Co.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Mary's Co.		f. STREET ADDRESS Park Hall - St. Mary's Co.	
3. NAME OF DECEASED (Type or print) Addie		First R.	Middle Tippett	Last 10	4. DATE OF DEATH 10 - 29 Month Day Year 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1884	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 904.7 DUE TO Multiple doubtus Congestive heart failure Arteriosclerotic cardio vascular disease Conditions, if any, which gave rise to immediate cause (b) Pneumonia (a), stating the underlying cause last. DUE TO (c) Fracture right hip. Accident				INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pt. fell to floor on July 13, 1956 sustaining a fracture of the right hip.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4:30 7-13-56 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital 20f. (City or town) Catonsville (County) 28, Md. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>George M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) George M. Kieffer, M. D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11/1/56	
22c. NAME OF CEMETERY OR CREMATORIALy		22d. LOCATION (City, town, or county) St. Mary's Co.		(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Malvina Mattingley Licklindtson</i>		ADDRESS 701		24a. REC'D BY REGISTRAR 10/31/56	
				24b. REGISTRAR'S SIGNATURE <i>Frank J. Bunker</i>	

BUREAU N.Y.

NOV 2 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10102

Reg. Dist. No.

41

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained by your file. For a burial permit, file pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Dundalk		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk		d. STREET ADDRESS 2927 Yorkway Rd.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Benny	Middle Abedine	Last Turani Jr.	4. DATE OF DEATH October 10 1956	Month October	Day 10	Year 1956
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 21, 1956		9. AGE (in years from last birthday) 3 1/2 yrs.	IF UNDER 1 YEAR Months 3	IF UNDER 24 HRS. Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) STUEBENVILLE, OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Benny Abedine Turani Sr.				14. MOTHER'S MAIDEN NAME Marilyn Hall				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address BENNY A. TURANI SR.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of Vomitus INTERVAL BETWEEN ONSET AND DEATH								
921.0 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vomited and aspirated.						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 10/10 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Dundalk (County) Balto. (State) Md		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>William V. Lovitt</i>		DATE SIGNED 10/10/56						
EXAMINER'S NAME (Type) William V. Lovitt, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-12-56		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) (State) BALTIMORE CO. MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wally Turb Bradley, Dundalk, MD</i>		ADDRESS 1111 Dundalk, MD		24a. REC'D BY REGISTRAR Oct. 15, 1956		24b. REGISTRAR'S SIGNATURE <i>Tom Kelly</i>		

WISCONSIN STATE POLICE DEPARTMENT
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.
RECEIVED
OCT 16 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4
 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with
 Form 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and file with
 the funeral director.
 As registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10119

CERTIFICATE OF DEATH

10103

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 16 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood Lane		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edna	Middle M.	Last Turnbaugh
4. DATE OF DEATH	Month Oct	Day 6	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 28, 1898
9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Morris		14. MOTHER'S MAIDEN NAME Elix Lytle	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-09-7406 17. INFORMANT William F. Turnbaugh, Owings Mills, Md.	
		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m. 19	20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1953, to Oct 6, 1956, that I last saw the deceased alive on 6 Oct, 1956, and that death occurred at 10 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Physician's Name (Type)	M.D.		ADDRESS (Street, city or town, state) Pikesville 8th & Oct 56
DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct, 8, 56	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Grove	22d. LOCATION (City, town, or county) Baltimore Co. Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons Reisterstown, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE 10-6-56
			24b. REGISTRAR'S SIGNATURE Mary B. Eline

CERTIFICATE OF DEATH

BUREAU Y
RECEIVED
OCT 9 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10104

38

Reg. Dist. No.

10120

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 1813 N. Mount Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First CLAUDE	Middle DONALD	Last URQUHART	4. DATE OF DEATH October 24 1956	Month	Day	Year
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5. SEX M	6. COLOR OR RACE N	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH August 27, 1902	9. AGE (in years last birthday) 54 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian	10b. KIND OF BUSINESS OR INDUSTRY Consolidated Cold Storage	11. BIRTHPLACE (State or foreign country) Phoebus, Va.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME John Urquhart	14. MOTHER'S MAIDEN NAME Alice Cross
---	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-03-0358	17. INFORMANT Mrs. Gertrude Urquhart - 1813 N. Mount Street	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion			Sudden
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO (c)			

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
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ACTUAL SIGNATURE <i>Charles F. O'Donnell</i>	M.D.	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 10/25/56
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EXAMINER'S NAME (Type) Charles F. O'Donnell, M.D.	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/28/56	22c. NAME OF CEMETERY OR CREMATORIAL Greenwood	22d. LOCATION (City, town, or county) (State) Trenton, New Jersey
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23. FUNERAL DIRECTOR'S SIGNATURE Charles R. Law	ADDRESS 802 Madison Avenue	24a. REC'D BY REGISTRAR DATE 10/29/1956	24b. REGISTRAR'S SIGNATURE <i>Mabel Gray</i>
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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your funeral director. File pages 1 and 2 with Registrar for burial permit. File page 3 with Registrar for removal.

BUREAU N.Y.

OCT 29 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10121

CERTIFICATE OF DEATH

10105-44

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be relied on by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 item 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Item 1 and
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY AA			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 11 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewater Beach		d. STREET ADDRESS Box 202			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First JACOB	Middle G.	Last WAGNER	4. DATE OF DEATH October 12 1956	Month October	Day 12	Year 1956	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 11/7/92	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 3	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY MASON		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Jerry Wagner		14. MOTHER'S MAIDEN NAME Elizabeth Gimmal				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 312-28-4359		17. INFORMANT Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 521X		BRONCHO-PNEUMONIA DIFFUSE MULTIPLE PULMONARY ABSCESSES							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.	Month VA	Day 19	Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VAH, Fort Howard, Md.	(County)	(State)	
21. I certify that I attended the deceased from October 1, 1956, to October 12, 1956, and that death occurred at 6:10 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED									
ACTUAL SIGNATURE C.J. Papastrat MD		M.D.							
PHYSICIAN'S NAME (Type) C.J. PAPASTRAT, M.D.						VAH, Fort Howard, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/16/56		22c. NAME OF CEMETERY OR CREMATORIAL Edwards Chapel Cemetery		22d. LOCATION (City, town, or county) Annapolis, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE John W. Taylor Jr.		ADDRESS Taylor Jr. Funeral Home		24a. REC'D. BY REGISTRAR D.C. 15 1956		24b. REGISTRAR'S SIGNATURE Dawson L. Hartley			
VS A15 (4) 15M 9/55									
Annapolis, Maryland									

BUREAU V. S.

OCT 17 1956

REGÉLIVÉD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please report to the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please report to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9979

CERTIFICATE OF DEATH

10106-44

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY BALTO		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK		c. LENGTH OF STAY IN 1b 17 YRS.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 65 DUNDALK AVE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK (22)		
3. NAME OF DECEASED (Type or print) MARGARET MILLER		First MILLER	Middle WAGNER	
4. DATE OF DEATH 10-24-1956	Month 10	Day 24	Year 1956	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15, 1867	
9. AGE (In years last birthday) 89 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	
13. FATHER'S NAME (?) MILLER	14. MOTHER'S MAIDEN NAME VNK.	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		
16. SOCIAL SECURITY NO. NONE		17. INFORMANT HENRY W. WAGNER	Address SAME ADDRESS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Renal Disease				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. f. p. m.	Month 19	Day 10-24	Year 1956	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 2 Kinshys Bldg 22	(County) BALTO. Co.	(State) Md.
21. I certify that I attended the deceased from 10-22 , 19 56 , to 10-24 , 19 56 , that I last saw the deceased alive on 10-24 , 19 56 , and that death occurred at 7 P.M. , from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>Jack C. Collins</i>	PHYSICIAN'S NAME (Type) JACK C. COLLINS	M.D.	ADDRESS (Street, city or town, state) 2 Kinshys Bldg 22 Baltimore	DATE SIGNED 10-26-56
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF 10-27-56	22c. NAME OF CEMETERY OR CREMATORIAL OAK LAWN	22d. LOCATION (City, town, or county) BALTO. Co. Md.	
23. FUNERAL-DIRECTOR'S SIGNATURE <i>Walter J. Gruca Bradley, Dundalk, Md.</i>	ADDRESS Walter J. Gruca Bradley, Dundalk, Md.	24a. REC'D BY REGISTRAR OCT 30 1956	24b. REGISTRAR'S SIGNATURE Newson L. Lasker	

MARYLAND STATE DEPARTMENT OF HENRY-GAVINMORE 18

CERTIFICATE OF DEATH

BUREAU V.

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10122

CERTIFICATE OF DEATH

10107

Reg. Dist. No.

44

1. PLACE OF DEATH
a. COUNTY

BALTO.

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BOWLEY'S QUARTERS

c. LENGTH OF STAY IN lb

40 yrs

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Md.

b. COUNTY

Balto.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Bowley's Quarters

X

d. STREET ADDRESS

Clarks Pt. Rd. Box 52

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Henry G. Seibel

4. DATE
OF
DEATH

Oct.

23

1926

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

Oct. 28-1885

9. AGE (In years
last birthday)

70 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Battery Worker

Retired

11. BIRTHPLACE (State or foreign country)

Germany

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Henry Seibel

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)

No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

William M. Stinchcomb Above

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

541.0

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause lost.

(b)

DUE TO

(c)

Gastric Hemorrhage

INTERVAL BETWEEN
ONSET AND DEATH
1 Day

Peptic Ulcer

3 Mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

CARCINOMA LARYNX

19. WAS AUTOPSY
PERFORMED?
YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from June 19, 1956, to Oct. 23, 1956, that I last saw the deceased alive on Oct. 22, 1956, and that death occurred at 5 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

Louis Semonoff

M.D.

1437 Funlage Ave

10/25/56

PHYSICIAN'S
NAME (Type)

Louis Semonoff

Balto 20, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Oct. 26-56

22c. NAME OF CEMETERY OR CREMATORIUM

Mt. Olivet

22d. LOCATION (City, town, or county)

Frederick Ave., Balto. Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

John G. Connally

ADDRESS

Essex, Md.

24a. REC'D BY REGISTRAR

DATE

Oct. 29, 1956

24b. REGISTRAR'S SIGNATURE

Dawson L Farley

WISCONSIN STATE GOVERNMENT DOCUMENTS LIBRARY
CERTIFICATE OF DEATH

1910

BUREAU V. S.

OCT 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1810108

10123 CERTIFICATE OF DEATH

Reg. Dist. No. 30

y. The

1. NAME OF DECEASED (Type or Print)		Michael L. Heaver		2. DATE OF DEATH	Oct. 5, 1956		
3. PLACE OF DEATH: A. Baltimore City, Maryland		Baltimore County		4. USUAL RESIDENCE (Where deceased lived. If institution: residence A. STATE Maryland B. COUNTY before admission)			
B. FULL NAME OF HOSPITAL OR INSTITUTION		Catskill 90 House in the Pines Nursing Home		C. CITY OR TOWN Baltimore		(If outside corporate limits, write RURAL and give township)	
c. LENGTH OF STAY IN BALTIMORE		Life		D. STREET ADDRESS 2405 East Federal Street			
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 YEAR MONTHS Days	11. UNDER 24 HOURS Hours Min.
Male		White	Widowed	No. 6, 1894	61 yrs		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Guard		Globe Detective Agency		Baltimore Md.		U.S.A.	
13. FATHER'S NAME		William E. Heaver		14. MOTHER'S MAIDEN NAME		Mary L. Pugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) O		16. SOCIAL SECURITY NO. 213-12-0486		17. INFORMANT		ADDRESS Florence C. Daniels - 2405 E. Federal St.	
18. I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH Carelessness of nurse & my mistake		INTERVAL BETWEEN ONSET AND DEATH Unknown			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) DUE TO					
		(B) DUE TO					
		(C) DUE TO					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20. AUTOPSY?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT <input type="checkbox"/> WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21F. HOW DID INJURY OCCUR?		<input type="checkbox"/>	
22. I certify that (I) (this hospital) attended the deceased from..... 5/0/48..... 19....., that (I) (we) last saw the deceased alive on..... 19....., and that death occurred at..... 1..... m., from the causes and on the date stated above.							
23A. SIGNATURE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/>		23B. ADDRESS M.D. STAFF PHYS. <input type="checkbox"/> 1513 N. Milburn St.		23C. DATE SIGNED 5/0/58			
24A. BURIAL, CREMA- TION, REMOVAL (Specify)		24B. DATE Oct. 8, 1956	24C. NAME OF CEMETERY OR CREMATORIAL Baltimore Cemetery		24D. LOCATION (City, town, or county) Baltimore Md.		(State)
DATE RECEIVED BY LOCAL REGISTRAR October 6, 1956		REGISTRAR'S SIGNATURE R. W. F. T. Harrys		25. FUNERAL DIRECTOR John C. Mullins Jr.		ADDRESS 2431 E. Oliver St.	

BUREAU Y-5

OCT 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10124

CERTIFICATE OF DEATH

10109

Reg. Dist. No.

30

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 5mths 6 dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland		d. STREET ADDRESS 2310 East Chase Street - Balto.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harry		First	Middle	Last	4. DATE OF DEATH October 24	Month	Day	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unknown		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY --		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? Russia		
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME unknown						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Generalized arteriosclerosis, severe.						
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. n. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Balto 17 md		20f. (City or town) Balto		(County) MD (State) MD
21. I certify that I attended the deceased fram alive an		Aug. 6, 1956, to Oct. 24, 1956, that I last saw the deceased Oct. 24, 1956, and that death occurred at 9:00 a.m., fram the causes and an the date stated above.				ADDRESS (Street, city or town, state) Balto		DATE SIGNED 10-24-56
ACTUAL SIGNATURE <i>Stella Wachster</i>		M.D.		SPRING GROVE STATE HOSPITAL 10-24-56				
PHYSICIAN'S NAME (Type) Stella Wachster, M. D.		Catonsville 28, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-25-1956		22c. NAME OF CEMETERY OR CREMATORIUM Windsor Mill Pct		22d. LOCATION (City, town, or county) Balto		(State) MD
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc</i>		ADDRESS Balto 17 md 2100 Eastern Pl.		24a. REC'D BY REGISTRAR Victor C. Harry		24b. REGISTRAR'S SIGNATURE <i>Victor C. Harry</i>		

CERTIFICATE OF DEATH

FEDERAL BUREAU OF INVESTIGATION

3

1956

RECEIVED

MARGIN RESERVED FOR BINDING

PLEASE WRITE ALONE, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

10110

1301

10125 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH. COUNTY <i>BALTIMORE</i>		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE <i>MARYLAND MD.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>CATENSVILLE</i>		LENGTH OF STAY (in this place) <i>4 years</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>House in The Pines</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>LOTHIAN</i>	
STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>Edith</i>	(Middle) <i>Shepherd</i>	(Last) <i>Welch</i>
4. DATE OF DEATH	(Month) <i>10</i>	(Day) <i>19</i>	(Year) <i>1956</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>SINGLE</i>	8. DATE OF BIRTH <i>10-19-70</i>
9. AGE last birthday <i>86 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>OWN HOME</i>	11. BIRTHPLACE (State or foreign country) <i>LOTHIAN, MD.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>
13. FATHER'S NAME <i>Owen Shepherd</i>	14. MOTHER'S MAIDEN NAME <i>KATE HILDIT</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>/ /</i>		17. INFORMANT AND ADDRESS <i>MCLEAN Welch, Annapolis, Md.</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 4201 Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (a) <i>Coronary Thrombosis</i> (b) <i>Hypertensive Cardio-Vascular Disease</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 day.</i> <i>10-7-56 (2.)</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>5/20/56</i>	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>5/20</i> , 1956, to <i>10-19</i> , 1956, that I last saw the deceased alive on <i>10-18</i> , 1956, and that death occurred at <i>6:30 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Walter K. Gallagher</i> (Degree or title) ADDRESS <i>Walter K. Gallagher M.D. 6209 Frederick Rd. Balt. 28, Md.</i> DATE SIGNED <i>10/19/56</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>	DATE THEREOF <i>10/21/56</i>	NAME OF CEMETERY OR CREMATORIAL <i>MT. ZION</i>	LOCATION (City, town, or county) <i>LOTHIAN, MD.</i> (State)
DATE REC'D BY LOCAL REG. <i>10/19/56</i>	REGISTRAR'S SIGNATURE <i>T.E. Harry</i>	24. FUNERAL DIRECTOR <i>B.L. Hopping & Son, Annapolis</i> ADDRESS <i>9911</i>	

BUREAU V. S.

OCT 23 1956

REGELVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10126

CERTIFICATE OF DEATH

10111
Reg. Dist. No. 32

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Balto.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN lb <i>Brick Walk Stone Chapel Ha.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		d. STREET ADDRESS <i>Brick Walk Stone Chapel Ha.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Brick Walk Stone Chapel Ha.</i>				d. STREET ADDRESS <i>Brick Walk Stone Chapel Ha.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>ELIZABETH</i>	Middle <i>W</i>	Last <i>WHARTON</i>	4. DATE OF DEATH <i>Oct 19</i>	Month <i>Oct</i>	Day <i>19</i>	Year <i>1956</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 19 1877</i>		9. AGE (In years lost birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Phila Pa</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George W Wharton</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Page</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>		16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Wm. A Howard</i>		Address <i>Pikesville Md</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i>		DUE TO <i>Cardio Vascular Renal disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs.</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b)		DUE TO <i>Generalized arterio sclerosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 yrs.</i>				
(c) <i>Hypertension</i>				INTERVAL BETWEEN ONSET AND DEATH <i>25 yrs.</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. b. p. m. <i>May 19 1956</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>May 19 1956</i> to <i>Oct 19 1956</i> , that I last saw the deceased alive on <i>Oct 19 1956</i> , and that death occurred at <i>9 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Palmer F C Williams M.D.</i>		ADDRESS (Street, city or town, state) <i>Pikesville 8. Md Oct 21 1956</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal Oct 22 1956</i>		22b. DATE THEREOF <i>Oct 22 1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Laurel Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Philadelphia Pa</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Henry Winkins Dms Co</i>		ADDRESS <i>4905 York Rd</i>		24a. REC'D BY REGISTRAR DATE <i>Oct 22 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Dorothy Newell</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in the funeral director,
line 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Lines 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

OCT 23 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10127

CERTIFICATE OF DEATH

Reg. Dist. No.

10112
20

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		c. LENGTH OF STAY IN lb 8 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 1901 Alson Drive 2817 Brighton Street			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1901 Alson Drive 2817 Brighton Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE		First W	Middle W	Lost WHITE SIDE	4. DATE OF DEATH OCTOBER 14, 1956	Month OCTOBER	Year 1956		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 23, 1866	9. AGE (In years lost birthday) 90 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER (rtd)		10b. KIND OF BUSINESS OR INDUSTRY BAPTIST CHURCH		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN WHITESIDE				14. MOTHER'S MAIDEN NAME ELIZA MAHOOD					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? UNKNOWN		16. SOCIAL SECURITY NO.		17. INFORMANT CHART SPRING GROVE STATE HOSPITAL Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX				<i>Cerebral hemangioma</i>		INTERVAL BETWEEN ONSET AND DEATH 24 hours			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Arteriosclerosis		(b)		<i>Arteriosclerosis</i>		years			
DUE TO				<i>Dementia</i>		years			
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 0	Day 0	Year 1956	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) OCT. 14, 1956	(County) OCT. 14, 1956	(State) MD
21. I certify that I attended the deceased from FEB. 9, 1956 , to OCT. 14, 1956 , that I last saw the deceased alive on OCT. 14, 1956 , and that death occurred at 12:00 M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Charles Ward ACTUAL SIGNATURE M.D.									
DATE SIGNED 10/15/56									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/56		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cem.		22d. LOCATION (City, town, or county) Baltimore, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Am. J. Pickner & Sons - Baltimore Md.		ADDRESS 10/17/56		24a. REC'D BY REGISTRAR DATE 10/15/1956		24b. REGISTRAR'S SIGNATURE J. E. Harry			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be retained by him. Then please remove carbon paper, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10128

CERTIFICATE OF DEATH

10113

Reg. Dist. No.

3d

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colombusville 28</i>		c. LENGTH OF STAY IN lb <i>Since Aug 30 - 1952</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Eastport</i>		d. STREET ADDRESS <i>701 Chesapeake Ave</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Spring Grove Hospital</i>				d. STREET ADDRESS <i>701 Chesapeake Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>DANIEL</i>	Middle <i>THOMAS</i>	Last <i>WIGGINS</i>	4. DATE OF DEATH <i>Oct 8 1872</i>	Month <i>10</i>	Day <i>27</i>	Year <i>1956</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct 8 1872</i>		9. AGE (In years to nearest yrs.) <i>84</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired naval officer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>US Navy Ret.</i>		11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>		(If yes, give war or dates of service) <i>1900 - 1919</i>		16. SOCIAL SECURITY NO.	17. INFORMANT <i>Isabelle B. Wiggins Wellington Penn</i>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i>		DUE TO <i>Arteriosclerotic Cardiovascular Disease</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <i>(b)</i>		DUE TO <i>(c)</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. st. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Annapolis</i>	(County) <i>Anne Arundel</i>	(State) <i>Md</i>	
21. I certify that I attended the deceased from <i>12-13</i> , 19 <i>54</i> , to <i>10-27</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>10-26</i> , 19 <i>56</i> , and that death occurred at <i>7:05 A.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Spring Grove Hospital Caton</i>		DATE SIGNED <i>10/27/56</i>			
ACTUAL SIGNATURE <i>Pena Becker</i>	M.D.								
PHYSICIAN'S NAME (Type) <i>John W. Taylor Son Annapolis</i>	ADDRESS		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Oct. 31-1956</i>		22b. DATE THEREOF <i>Oct. 31-1956</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Naval Academy</i>	22d. LOCATION (City, town, or county) <i>Annapolis</i>	(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John W. Taylor Son Annapolis</i>		ADDRESS		24a. REC'D BY REGISTRAR <i>10/27/56</i>		24b. REGISTRAR'S SIGNATURE <i>J.W. Taylor</i>			

OCT 30 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10129 CERTIFICATE OF DEATH

10114

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Waldorf, Maryland.		b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Md.		c. LENGTH OF STAY IN lb 2 1/2 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf		d. STREET ADDRESS Route #1 - Box 111		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James Edward		First	Middle	Last	4. DATE OF DEATH 10	Month	Day	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 5/15/39	9. AGE (In years last birthday) 17 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) patient in hospital		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Carl E. Williams		14. MOTHER'S MAIDEN NAME Melda Ruth Mannis						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Rosewood Records		Address Owings Mills, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation (inspired multiple food particles DUE TO in bronchus). Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. } (b) Epilepsy - grand mal type DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)		
21. I certify that I attended the deceased from July 16, 1956 , to October 10, 1956 , that I last saw the deceased alive on October 10, 1956 , and that death occurred at 12:45PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Owings Mills, Maryland. DATE SIGNED 10/11/56								
ACTUAL SIGNATURE Harry G. Butler		PHYSICIAN'S NAME (Type) Harry G. Butler, M.D.		Gwings Mills, Maryland,				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10-15-56	22c. NAME OF CEMETERY OR CREMATORIUM PARKLAWN Cem.		22d. LOCATION (City, town, or county) Rockville, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Robert C. Lumsden, Belvedere, Md.		ADDRESS 10-16-56		24a. REC'D BY REGISTRAR Mary S. Elise		24b. REGISTRAR'S SIGNATURE		

DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

NAME

ADDRESS

PHONE NUMBER

CAUSE OF DEATH

TIME OF DEATH

PLACE OF DEATH

NAME OF DOCTOR

NAME OF HOSPITAL

NAME OF FUNERAL HOME

NAME OF ATTENDING PHYSICIAN

NAME OF ATTENDING NURSE

BUREAU V. S.

OCT 16 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10115

9980

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>BALTIMORE</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK - 22</u>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		d. STREET ADDRESS <u>1912 QUEENSWAY</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1912 Queenway</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Lorraine</u>		First	Middle	Lost	4. DATE OF DEATH <u>WILSON</u>	Month	Day	Year
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>DEC. 18, 1869</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>REMYER JACOB REMERS</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE GERMRAUTH</u>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>422.1</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>ROSALIE McNALLY 1912 QUEENSWAY</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Accident</u>		DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u>		(b) <u>Arterio-Sclerotic Cardio Vas Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u>		
(c) <u>Senility</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>New</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> p. m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6800 Moelington Rd</u>		20f. (City or town) (County) <u>BALTO.</u> (State) <u>MD.</u>
21. I certify that I attended the deceased from <u>Oct. 1956</u> to <u>Oct 15</u> , 1956, that I last saw the deceased alive on <u>Oct. 24</u> , 1956, and that death occurred at <u>11:55 A.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <u>Dundalk - 22 - Md</u>		DATE SIGNED <u>10/26/56</u>
ACTUAL SIGNATURE <u>M.B. Davis</u>		M.D.						
PHYSICIAN'S NAME (Type) <u>M.B. Davis MD</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT. 29, 1956</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>BALTIMORE</u>		22d. LOCATION (City, town, or county) <u>CITY</u>		(State) <u>MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Neher 401 S. Chester St.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE <u>10/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. M. Kelly</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/55

MARYLAND STATE DEPARTMENT OF HUMAN RELATIONS
CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.
OCT 20 1956

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be referred by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed in the funeral director's office.
 This certificate should be detached for use as the burial-transit permit. Then please remove carbon paper, sign pages 1 and 3, and file in the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 44	
10130 8,12 Film G205 10-16-56 et CERTIFICATE OF DEATH													10116
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST POINT				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EAST POINT									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7410 Belmont ave				d. STREET ADDRESS 7410 Belmont ave									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) Maryanna Wisniewski				First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
5. SEX Female				6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1885	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours	13. Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Handwife				11. BIRTHPLACE (State or foreign country) Poland					
12. CITIZEN OF WHAT COUNTRY? U.S.A.													
13. FATHER'S NAME Michael Balcerak				14. MOTHER'S MAIDEN NAME unknown									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 260X				16. SOCIAL SECURITY NO. 219-03-6818				17. INFORMANT Floyd Wisniewski					
								7410 Address Belmont ave					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X				Cerebral Hemorrhage 5 months									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				Diabetes Mellitus 6 years									
(b)				Hypertension 44 years									
DUE TO													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from alive on Oct 12, 1956, and that death occurred at 6:15 AM, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) M.D. 1010 North Point Rd. 10/13/56								DATE SIGNED 10/13/56	
ACTUAL SIGNATURE Morris A. Jacobs				PHYSICIAN'S NAME (Type) MORRIS A. Jacobs									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF OCT 16, 1956				22c. NAME OF CEMETERY OR CREMATORIAL HOLY ROSARY CEM. GERMAN HILL PR. DUNDACK				22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John McKeever				ADDRESS 4015 Chester St.				24a. REC'D BY REGISTRAR DATE 10/16/56				24b. REGISTRAR'S SIGNATURE	

STATE DEPARTMENT OF INVESTIGATION - ALABAMA

BUREAU

NYT 15 1956

REGELY ED

10131

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10117

Baltimore Co. CERTIFICATE OF DEATH

Reg. Dist. No.

The

POINT PEN.

THIS IS A PERMANENT RECORD.

Every item of information she carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FURNISHED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

1. NAME OF DECEASED
(Type or Print)

WASHINGTON WORRELL WOOLSON Jr.

2. DATE
OF
DEATH

10/11/56

3. PLACE OF DEATH:

A. Baltimore City, Maryland

B. FULL NAME OF
HOSPITAL OR
INSTITUTION

55 AT HOME

20

c. Length of stay in Baltimore

25 yrs

Yrs.
Mos.
Days

5. SEX

M

6. COLOR OR RACE

CAU

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

INSURANCE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED (Specify)

married

10B. KIND OF BUSINESS OR INDUSTRY

—

13. FATHER'S NAME

WASHINGTON WORRELL WOOLSON Sr.

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no or unknown)

(If yes, give war or dates of service)

D

16. SOCIAL SECURITY NO.

4. USUAL RESIDENCE (Where deceased lived. If institution: residence

A. STATE

Md

B. COUNTY

1

before admission)

C. CITY OR TOWN

(If outside corporate limits, write RURAL and give township)

D. STREET ADDRESS (If rural, give location)

1811 ABERDEEN RD

8. DATE OF BIRTH

FEB 28 1885

9. AGE (In years
last birthday)

71

11. BIRTHPLACE (State or foreign country)

PHILADELPHIA, PA.

12. CITIZEN OF
WHAT COUNTRY?

U.S.

14. MOTHER'S MAIDEN NAME

MARY BETTS

17. INFORMANT

WIFE

ADDRESS

18. 420.0

DISEASE OR CONDITION DIRECTLY
LEADING TO DEATH(This does not mean the mode of dying, e.g.,
heart failure, asthenia, etc. It means the disease,
injury or complication which caused death.)

CAUSE OF DEATH

INTERVAL BETWEEN
ONSET AND DEATH(A) ARTERIOSCLEROTIC HEART
DUE TO DISEASE - CONGESTIVE

4-5 yrs.

(B) HEART FAILURE

(C) GENERALIZED ARTERIOSCLEROSIS

MEDICAL CERTIFICATION

DISEASES OR CONDITIONS, IF ANY, GIVING
RISE TO THE ABOVE CAUSE (A) STATING THE
UNDERLYING CONDITION LAST.

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO
CAUSE OF DEATH, ENTER IN
PART I OR PART II

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION
WAS PERFORMED

20. AUTOPSY?

YES NO 21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY21E. INJURY OCCURRED
WHILE AT WORK NOT WHILE AT WORK

m.

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from OCT 1 1956 to 1956,
Oct 11 1956, that (I) (we) last saw the deceased alive on Oct 10 1956,
and that death occurred at 2:00A.m., from the causes and on the date stated above.

23A. SIGNATURE

Attending Phys.

Med. Director Staff Phys.

23B. ADDRESS

M.D.

3009 EVERGREEN AVE

10/11/56

23C. DATE SIGNED

24A. BURIAL, CREMA-
TION, REMOVAL (Specify)

Burial

24B. DATE

10/15/56

24C. NAME OF CEMETERY OR CREMATORIAL

24D. LOCATION (City, town, or county) (State)

DATE RECEIVED BY LOCAL REGISTRAR

10/12/56

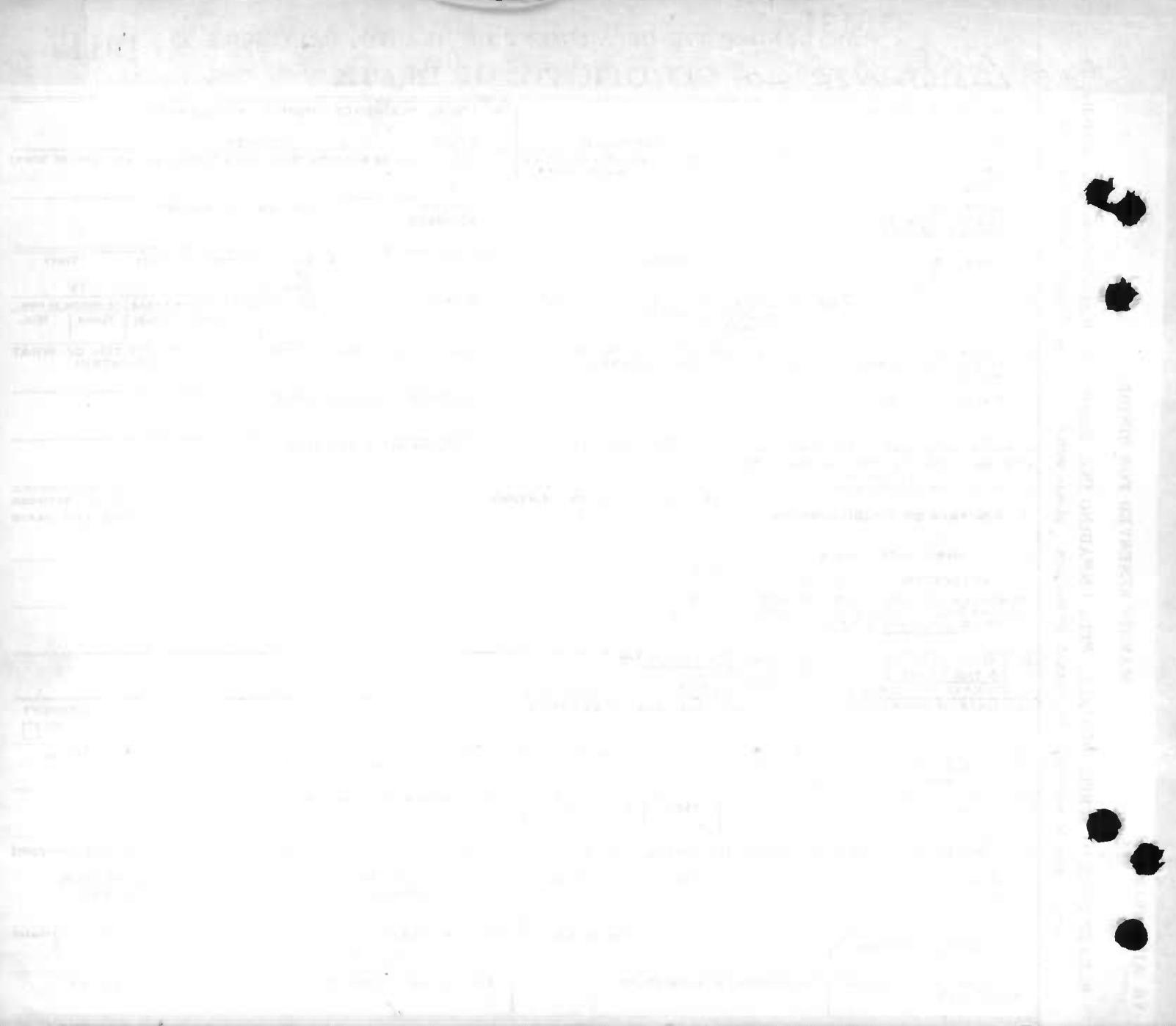
REGISTRAR'S SIGNATURE

H. H. Hodge

25. FUNERAL DIRECTOR

Leonard J. Ruck 5305 Hartford

ADDRESS



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your funeral director or removed.

VS. A15ME(5)
5M 9/55 ✓

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10132 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10118
Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STATE MD b. COUNTY Balto.	
CATIONSVILLE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6310 Frederick Ave.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
3. NAME OF DECEASED (Type or print) John Oliver Zimmerman		First	Middle	Last	4. DATE OF DEATH October 31, 1956
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1891	
9. AGE (In years 100 yrs. 85 yrs.)		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Route Man		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
10c. FATHER'S NAME Joseph Zimmerman		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? USA USA	
13. MOTHER'S MAIDEN NAME Sophie (unknown)		14. INFORMANT Mrs. Gertrude M. Zimmerman		Address 6310 Frederick Ave	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-10-1200		17. INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO Coronary thrombosis			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { b}		DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Western Gem	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Geo. S. M. Kieffer M.D.		DATE SIGNED Oct. 31, 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11-3-56		22b. DATE THEREOF Western Gem	22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) Balto. Md.		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Lichten & Sons</i>		ADDRESS Balto. 17th St. Nov. 5, 1956	24a. RECD BY REGISTRAR DATE J. E. Harry		
			24b. REGISTRAR'S SIGNATURE		

EXAMINER'S CERTIFICATE OF DATA

RECEIVED NOV 7 1956 **BUREAU V. S.**